STATE TITLE V BLOCK GRANT NARRATIVE
STATE: UT
APPLICATION YEAR: 2006

I. GENERAL REQUIREMENTS

A. LETTER OF TRANSMITTAL

The Letter of Transmittal is to be provided as an attachment to this section.

B. FACE SHEET

A hard copy of the Face Sheet (from Form SF424) is to be sent directly to the Maternal and Child Health Bureau.

C. ASSURANCES AND CERTIFICATIONS

The Utah Department of Health has submitted the Assurances and Certifications to the authorized signator and has on file the signed Assurances and Certifications dated June 24, 2005. The State Title V Office has on file a copy of the Assurances and Certifications - non-construction program, debarment and suspension, drug free work place, lobbying program fraud, and tobacco smoke. They are available at any time for review upon request. The state Title V agency is compliant with all the federal regulations governing the Title V funding allocated to Utah.

D. TABLE OF CONTENTS

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published June, 2003; expires May 31, 2006.

E. PUBLIC INPUT

Public Input
As we planned the needs assessment, we changed the public input process. We decided to gather public input on the needs of the three MCH populations and health services or system. Division staff developed a key informant survey (attached) on health issues for the three populations and health care services in conjunction with staff and outside partners. Those contacted included local health departments, community health centers, private providers, State ICC members, Ethnic Health Advisory Committee members, advocacy organizations, parents of children and youth with special needs, agencies working with mothers and children, etc. We encouraged wide distribution of the survey to increase responses.

Almost 700 individuals (694) were directly contacted, with 411 returned surveys, a response rate of 59% (based on direct contacts). Of the surveys completed, 83% were done online. Parents comprised the largest responder group at 22%, followed by local health department staff at 17%.

The priorities were presented to the MCH/CSHCN Advisory Committee for input. The subcommittees reviewed the results, the current state priorities and performance measures to make recommendations on the top three or four issues. Their recommendations were reviewed by the Title V leadership team, including the family advocate, to determine the final list of priorities. We will make the final application available on the website for further public comment.

II. NEEDS ASSESSMENT

In application year 2006, the Needs Assessment must be provided as an attachment to this section.

III. STATE OVERVIEW

A. OVERVIEW

Utah is the fifth fastest growing state in the nation. Utah's population estimate for 2003 was 2,351,467, a 5.3% increase from the 2000 Census compared to 3.3% for the nation. Utah experienced a 29.6% population increase from the 1990 to the 2000 Census. According to the Governor's Office of Planning and Budget estimates, by the year 2010, Utah's population will grow to 2.8 million.

While Utah continues to be predominately white, ethnic minorities now make up a larger portion of the state's population, comprising 16.2% of the state's total population compared to 14.6% five years ago. In 2003, the population of every racial and ethnic group, except White (both Hispanic and non-Hispanic), grew at a higher rate than the state. During 2000 to 2003, among the five race categories, the highest growth rate occurred among the Black population (16.6%), followed by Asian (15.5%), Native Hawaiian and Pacific Islander (10.1%), American Indian/Alaskan Native (7.2%), and White (4.9%). In 2003, Hispanics accounted for 10% of state's total population, a 15.8% increase since 2000. Refugee populations in Utah are growing, along with the Hispanic populations, with resultant increasing need for language translation services. These factors impact the health care system's ability to adequately address the needs of the diverse populations.

Utah continues to have the youngest population in the nation with a median age of 27.7 years. The American Community Survey Summary indicated that 32% of the Utah population was under the age of 18 years in 2003. For 2002, Utah has the highest birth and fertility rates in the nation at 21.2 and 90.6 compared to 13.9 and 64.8 for the nation.

For many years Utahns have had larger households compared to the nation. In 2003, Utah's household size was 3.07 compared to the national average of 2.61. Utah's average family size was 3.55 compared to the national average of 3.19. The percent of Utah family households with children is 30% higher than the rest of the nation, 42.0% versus 32.2%. Households comprised of single mothers with children are lower in Utah than the nation, (5.7% vs. 7.6%). Utah Hispanic household size was much larger than the U.S. (3.9 vs. 3.5.)
Utah's median household income was somewhat higher than that of the U.S. However, Utah's households are also larger with a significantly lower per capita income in Utah than in the U.S. overall. Based on the 2003 American Community Survey Summary, Utah's median household income of $52,481 was slightly higher than the U.S. average of $52,273, ranking Utah 15th nationwide. Due to larger families in Utah, the per capita income ranked the state 45th in the nation at $18,905.

Based on the 2003 American Community Survey, Utah had a significantly higher percentage of high school graduates at 90% versus 84% nationally among individuals 25 years and older with a high school diploma. Utah's population is similar to the national population for percent of the population with a bachelor's degree or higher degree (26.2% in Utah compared to 26.5% of the U.S. population). Even though the proportion of Bachelor's degree and higher education achievement was comparable, Utah has a higher percentage of individuals with some college but no degree at 29% compared to 20% nationally. The high school drop out rate in Utah is not as high as the U.S. at 6% of youth ages 16 to 19 years old versus 8% at the national level.
The National Center for Education Statistics identified Utah with the lowest funding per elementary and secondary student during 2001 to 2002 at $4,900. The national average was $7,734 per student with the District of Columbia spending the most at $12,102 per student.

Utah's predominant religion counsels against the use of tobacco and alcohol which consequently results in a lower incidence of diseases associated with abuse of these substances, such as liver disease, alcoholism, and lung cancer. Utahns pride themselves on family values and support many efforts to improve maternal and child health. The political environment is conservative with a fairly large group of individuals who hold anti-government philosophies that at times make it difficult to obtain state funding for state agency programs.

Utah is largely a rural and frontier state, with the majority of the state's population residing along the Wasatch Front, a 75 mile strip running from Ogden (north) to Provo (south) with Salt Lake City, the state's Capitol, in between. The Wasatch Front comprises only 4% of the state's landmass, but 76% of the state's population resides here. The rest of the population (24%) resides in the remaining 94% of the state's land mass comprised of rural areas of more than six, but less than 100 persons per square mile and frontier areas of less than six persons per square mile. Five percent of the state's population lives in the frontier area (70% of the land mass), and 19% lives in the rural portion (26% of the land mass). The geographic distribution of the state's population presents significant challenges for accessing health care services for those living in the rural and frontier areas as well as for delivery of health care services. In the rural and frontier areas, many residents are not able to readily access health care services due to long travel distances and lack of nearby hospital facilities and health care providers, especially specialists. Specialists are not available to rural/frontier residents except by traveling hundreds of miles. In addition residents living in the rural/frontier areas may be reluctant, if not unwilling, to utilize certain services, such as family planning, mental health, because of concern for confidentiality and anonymity in seeking these services in a very small town.

Based on the Utah Health Status Survey (UHSS), 10.2% of Utah's population reported no health insurance in 2004, a steady increase from 8.7% in 2001 and 9.1% in 2003. The proportion of uninsured has increased in the maternal and child populations as well. In 2004, 8.15% of children under age 18 were uninsured compared to 7.3% in 2003 and 6.8% in 2001. Of females ages 18-49, 13.9% 11.3% reported no health insurance in 2003 compared to 10.8% in 2001. More than a quarter (25.8%) of the Hispanic population reported no insurance in the 2001 UHSS, the only year the data were available. The steadily climbing rates of uninsured individuals in the state especially children and women of childbearing ages, is very concerning. The Governor recently sponsored a state summit to discuss issues related to a state plan to address the increasing rates.

Of particular concern is meeting health care needs of Hispanics due to the increasing number without documentation. These families are more difficult to reach due to language barriers; cultural beliefs about preventive health care; transportation constraints; and ineligibility for many government programs. Prenatal care for women without documentation is a problem since they are not eligible for public assistance, even though their newborns will be citizens and eligible for benefits.

Utah Title V programs have worked to promote increasing awareness of the Department of Justice regulation announced in 1999 that assures families that enrolling in Medicaid or the Children's Health Insurance Program will not affect immigration status. While programs, such as the Covering Kids and Families Utah Project, have promoted this information, many families remain skeptical about applying for any government programs for fear they will be reported to the U.S. Citizenship and Immigration Services or that their immigration status will be affected. This fear and distrust of government agencies has been compounded by The U.S. Citizenship and Immigration Services (formerly INS) raids on Utah businesses with a large undocumented worker population resulting in deportation of the workers.

Maternal and child health services, including services for children and youth with special health care needs, are provided in various settings: through medical homes/private providers; local health departments, community health centers, a clinic for the homeless, migrant health clinics, and several free clinics; itinerant clinics offered through the CSHCN Bureau to rural communities without specialty providers; and, specialty centers, such as the University of Utah Health Sciences Center, Primary Children's Medical Center, and Shriners Hospital for Children, and several tertiary centers for high risk perinatal and neonatal care. These centers of excellence provide centralized specialty and subspecialty services to pregnant women, infants and children with high-risk pregnancies, neonatal intensive care, and numerous disabling conditions, such as asthma, hemophilia, cystic fibrosis, diabetes, Down syndrome, cancer and orthopedic disorders. Although this allows for better coordination of care because there are fewer providers, it also presents a problem of service delivery to high-risk mothers and infants, and special needs children in rural Utah. CSHCN provides direct services in their Salt Lake City office for three specific populations: follow-up of premature infants, developmentally delayed preschool aged children and developmentally/behaviorally disorder school

aged children and youth.

Utah's public health system consists of 12 autonomous local health departments (LHDs). Six of the 12 local health departments are multi-county districts and cover large geographic areas. Many districts include both rural and frontier areas within the service region. Many local health departments are gradually moving away from direct services, recognizing that they do not have the capacity to provide primary care for those living in their communities.

Services available through LHDs vary depending on priorities as established by the health district. For example, direct prenatal services are no longer available through LHDs, although two districts provide clinic space and support staff for prenatal clients served by University of Utah Health Sciences Center providers. Family planning services are available only through mid-level practitioners in several health district clinics. The shift away from direct services provided by LHDs reflects the changing public health system to focus more on core public health functions, including health promotion and prevention services.

The ten community health centers and the Wasatch Homeless Clinic provide primary care to underinsured and uninsured MCH populations. Seven of the ten community health centers are located in rural areas of the state. Two mobile Utah Farm Worker clinics operated under Salt Lake Community Health Centers, Inc. are co-located with Wasatch Front community health centers in Provo and Ogden with a third mobile clinic in Enterprise, Utah. Utah Farm Worker Program's permanent site is located in Brigham City. Unfortunately, many of Utah's Hispanic workers, especially along the Wasatch Front, are not engaged in farm work and therefore do not qualify for these services.

Since 1995 Medicaid participants living in Utah's urban counties have been required to enroll in a managed health plan. This requirement is the Choice of Health Care Delivery Program, which is allowed under a federally approved freedom-of-choice waiver. As recently as 2002, the Utah Department of Health's Division of Health Care Financing (HCF), Utah's Medicaid agency, contracted with four different managed health plans to provide services to Medicaid participants in Utah's urban counties. Since then health plans have struggled financially to continue delivering services to the Medicaid population. Currently, Medicaid has contracts with three health plans to deliver services to enrollees in Utah's four urban counties, including children with special health care needs. Two of these plans are managed care plans; the third is a preferred provider network. One health plan continues to expand into rural areas of the state providing an option for Medicaid participants in most areas of the state. At the present time enrollment for rural Medicaid participants is voluntary, allowing them the option of choosing either fee-for-service, a primary care provider or a health plan if available. Medicaid participants in all but three rural counties are enrolled in a Prepaid Mental Health Plan for behavioral health services.

The hospital health care system for MCH populations is well developed in Utah, with five large tertiary perinatal centers and two tertiary children's hospitals. Each of these centers has University of Utah Health Sciences faculty assigned and is well recognized throughout the state and the Intermountain West as a consultation and referral center for obstetrical and pediatric providers. These centers work with hospitals within their referral areas to encourage consultation and referral as needed, depending on the condition of the mother, infant or child. During 2004, St. Mark's Hospital, which had employed neonatologists in the past, hired a maternal-fetal medicine specialist, qualifying the hospital as Utah's fifth tertiary perinatal center for perinatal care.

CFHS staff interfaces with faculty and staff from these centers through various efforts, including Perinatal Mortality Review, Child Fatality Review, Perinatal Taskforce, Perinatal HIV Taskforce, clinical services, joint projects, and other committee work. Through these efforts, the need and importance for consultation and referrals between levels of service are emphasized via reports of mortality review findings, or reports on specific topics, such as low birth weight.

Utah, not unlike other areas of the country, suffers from a shortage of certain types of health care

providers in different geographic areas, including nurses, neonatologists, dentists, mental health professionals, etc. Provider shortages exist throughout the state. The Health Professional Shortage Area (HPSA) maps detail areas of the state with provider shortages for medical, dental and mental health providers. Access to dentists in Utah is a major issue, particularly for Medicaid participants and for individuals living in rural/frontier areas of the state. Mental health providers, especially those specializing in children's mental health, are limited, in part due to the mental health system in the state which is a Medicaid carve-out serving primarily the chronically mentally ill, but not necessarily those with acute conditions.

Access to maternal and child health care varies depending on the geographic area of the state. According to Health Professional Shortage Area surveys conducted between 2000 and 2004, some areas in Utah have high ratios of women of childbearing ages to providers, resulting in limited access to a reproductive health provider in their area. Women in rural communities may have to travel many miles to a provider's office and/or hospital. More than half of the counties (16 out of 29) are without any obstetrician-gynecologist with several counties reporting as few as 1 provider to 10,000 women of childbearing age, creating a need to assure better access to consultation services for rural providers. Even where prenatal care providers are more numerous, under- and uninsured women may be confronted with caps on the number of women an agency is able to accommodate including Presumptive Eligibility determination. However, gaps exist in some areas of the state due to specific geographic situations, such as Wendover, uniquely located in two states with different rules and regulations governing federal and state programs.

Since the income eligibility level for Utah's Prenatal Medicaid program has not been increased from 133% of the FPL since its beginning in 1990, many women and their families, best categorized as working poor, are ineligible for health care coverage, making it difficult for them to access health care, especially prenatal and family planning services. Medicaid's current eligibility level for children birth to 5 years is 133% FPL and 100% FPL for children 6 - 18 years of age. Both the prenatal and the children's programs require an asset test for eligibility determination. The asset test prohibits many families that otherwise would qualify for the program from being eligible, such as a savings account of approximately $3000. Bills have been proposed in the recent Legislative Sessions to remove the asset test without success.

Utah CHIP Program began in 1999 with an income eligibility of 200% of the FPL for children from birth to 18 years. The Program has suffered from budgetary limitations and has had to cap enrollment to stay within its budget. Additional funding in the 2004 and 2005 Legislative Sessions have enabled the program to increase enrollment numbers and with the additional funding in 2005, the program will now attempt to maintain open enrollment until budget limitations are reached.

Presumptive eligibility for prenatal Medicaid has been problematic in some areas of the state, especially in the urban areas with limited Presumptive Eligibility (PE) sites. To increase access to PE along the Wasatch Front, application via phone was instituted 2001 enabling over 2,000 women annually to apply by this method. Co-location of PE workers and Medicaid eligibility workers has also assisted women in accessing Medicaid eligibility faster. For the occasional situation where the waiting times for appointments are too long, clients are referred directly to the department of Workforce Services workers to make a direct Medicaid application. Pregnant clients ineligible for PE or Medicaid and unable to afford private care are referred to one of two University of Utah Health Sciences Center prenatal clinics located in local health departments or to one of six community health centers located along the Wasatch Front offering sliding fee schedules.

Access to low-cost maternal and child health care services provided by community health centers is problematic in several areas of the state since they are not located in many rural areas. Fortunately in the past couple of years, three new community health centers have opened in the more rural areas of the state. The Association for Utah Community Health, the state's primary care association, works to promote development of new or expansions of existing community health centers in Utah.

Other areas of the state where access to low-cost health care services is problematic include: Tooele

County, especially the Wendover area; Wasatch and Summit Counties; Bear River Health District; TriCounty Health District; and portions of Central and Southeastern Utah Health Districts Native American Indian women and their children in Southeastern Utah may have to travel to Tuba City, Arizona for services if they wish Indian Health Service to pay for their care. While the local health departments in all of these areas receive Title V funds, demand for services far outstrip the amount of funding available.

The Child Health Evaluation and Care (CHEC) Program, Utah's Early and Periodic Screening, Diagnosis and Treatment Program, provides coverage for a variety of services for Medicaid-covered children that are recommended by the American Academy of Pediatrics. The guidelines for the CHEC Program are very similar to the AAP recommendations. The Utah Pediatric Partnership to Improve Healthcare Quality found that services and quality varied among small groups of pediatric practices that were engaged in quality improvement processes. These practices served children enrolled in Medicaid and children with private insurance.

Most specialty and sub-specialty pediatric providers are located along the Wasatch Front, including the state's tertiary pediatric care centers, Primary Children's Medical Center and Shriners Hospital for Children. The location of most pediatric specialists and sub-specialists in the most populous area of the state presents a problem for provider access for special needs children in rural Utah. In several counties of Utah, there are no pediatricians or sub-specialists, necessitating families to drive long distances to access care for their children. In most cases, there is only limited additional itinerant coverage from the private sector for this large geographic area. In rural counties, health care is often provided to children through family practice physicians, local health departments or community health centers.

Title V programs across the nation are working toward the six CSHCN core components of: 1) family/professional partnership at all levels of decision-making; 2) access to comprehensive health and related services through the medical home; 3) early and continuous screening, evaluation and diagnosis; 4) adequate public and/or private financing of needed services; 5) organization of community services so that families can use them easily; and 6) successful transition to all aspects of adult heath care, work and independence. Over the past 5 years, numerous successful public and private projects have expanded and improved the service system for Utah CYSHCN and families at both the state and community level. Despite significant changes and improvements in the system, gaps in services and needs remain as evidenced by data from surveys and reports from parents and providers.

Although components of Utah's system of care have greatly improved for families, the system itself has become increasingly complex, especially in the areas of funding, insurance coverage and the increasing number of Utah residents who are culturally or linguistically diverse. Utah has seen a series of funding cuts over the past 5 years, affecting health, educational and social services across the state. Though Utah has the highest birthrate in the nation and a rapidly growing population, there has been no appreciable increase in the availability of specialty pediatric services over the past several years. Families continue to face formidable barriers in accessing services and coordinating care for their CYSHCN.

The CSHCN Bureau is addressing these issues through the many initiatives, some of which include the Medical Home Initiative and MedHome Portal website, Telehealth, traveling multidisciplinary clinics, community based case management teams, Baby Watch/Early Intervention and collaboration with Family Voices and the Utah Leadership Education in Neurodevelopmental Disabilities (ULEND) grant. These initiatives are described in greater detail later in this document.

Due to ever tightening budgets, the state title V agency, the Division of Community and Family Health Services of the Utah Department of Health, has been faced with replacing state funds with federal funds to offset state budget cuts. As a result, in order to maintain established programs and services, more federal dollars are being allocated to offset state budget cuts. The changing economy is resulting in less flexibility with dollars than in previous years. State staff are sensitive to the impact

that state budget cuts have on local agencies as well, and often will preserve the allocation of federal contract dollars to local agencies by eliminating state level funding.
Competition for funding is becoming a matter of carefully balancing what exists with current need, consideration of how the dollars will have the most impact. State level needs, as well as local level needs, may be sacrificed during a time of economic downturn. As an example, ongoing discussions at combined CDC and HRSA Early Hearing Detection and Intervention (EHDI) meetings have suggested the possibility that HRSA EHDI funds could be rolled into the MCH Block Grant. Requiring states to cover previously funded programs (in this case the identification of newborns with hearing loss) through the MCH Block Grant could create additional financial obstacles particularly when the required outcome has been legislatively mandated by the state.

In conducting the needs assessment for women of childbearing ages, infants, children and youth, especially those with special health care needs, the Title V agency queried its partners about the needs of the three population groups as well as the health care services or systems needs. The needs identified in order of importance under each category, were:
Mothers and infants
Unplanned pregnancies
Obesity
Depression or other mental health problems
Closely spaced pregnancies
Poor nutrition during pregnancy
Children
Lack of physical activity
Obesity
After school supervision
Teen pregnancy
Depression or other mental health problems
Children and Youth with Special Health Care Needs
Lack of physical activity
Lack of respite care
Depression or other mental health problems
Transition to adult life and self-sufficiency
Lack of childcare
Health Care Services or Systems
Dental insurance
Obtaining financial help for health care
Health insurance
Services not covered by insurance
Dental care

This input from a variety of partners, especially families, has been very helpful in guiding discussions among the three subcommittees of the MCH/CSHCN Advisory Committee to identify the state top priorities or unmet needs of Utah's mothers and children. The overall needs assessment process has afforded the state Title V agency, its staff and its partners to examine the current status of health of the state's population and the health system needs.

Documenting disparities at times is difficult given small numbers of populations in which to draw significance. The Department has endeavored to include data on subpopulations in the state in an attempt to better quantify the issues faced by various groups of individuals. The 2004 Legislature appropriated funding for the Center for Multicultural Health, which was supplemented in the 2005 Legislative Session with additional funding. The Center is housed in the Division of Community and Family Health Services and assists the Department of Health in identifying priorities and needs of specific key populations in the state, updating an Ethnic Health Report, assessing the adequacy of ethnic data from common public health data sources and recommending improvements, inform ethnic communities about the Center's efforts and activities, and developing guidelines for cultural effectiveness for UDOH programs. The Center will play an important role in bridging the needs of

ethnic communities in Utah and the work of the Department of Health and its partners in addressing these needs.

In addition, the Department has hired a new Liaison to the Native American communities in the state, which will be helpful to programs attempting to address the unique needs of the Native American populations.

The health care system in Utah is developing more cultural awareness, especially as the population of Utah changes. The results of a 1997 Department of Health qualitative study of ethnic populations indicated that individuals of ethnic populations feel as though they were inadequately or poorly treated because of their ethnicity; they wanted health care providers of their own ethnicity or providers who could relate to them and their beliefs; they want health care providers to ask them what they need and not assume what they need; they had to wait long times while others who arrived later were seen earlier; they need access to interpreters and materials in own languages; they want acceptance of their beliefs about health and prevention (one doesn't go to doctor if not sick); and, they want providers to be sensitive to gender issues. The Department plans on conducting another qualitative survey of ethnic populations in the state to determine current priorities.

The Division has built capacity for data analysis through the Data Resources Program. The Program has staff assigned to each of the three populations served by Title V programs. The Department has also built data capacity by forming the Center for Health Data which includes Vital Records and Statistics, survey data collection capacity (BRFSS, YRBSS, etc.), development of an internet-based query system for health data (http://ibis.health.utah.gov/) that provides access to 120 different indicators and access to data sets, such as birth and death files, BRFSS, PRAMS, YRBS, Utah Health Status Survey, hospital and emergency department data, population estimates, and Cancer Registry. The Center for Health Data provides access to large data sets for analysis by Department staff (and others outside the Department as appropriate), and works with programs in the Department to assist in data analysis as needed. Medicaid has developed a data warehouse for Medicaid data that is used by Title V to link with vital records data to track outcomes for Medicaid participants.

The Data Resources Program has expanded capacity to address data needs of MCH and CSHCN programs to include a data analyst assigned to CSHCN and another dedicated to two programs, WIC and Immunizations. The latter position is jointly funded with USDA WIC Program and CDC Immunization Program funds, making for a strong partnership between the two programs. This expansion of capacity has greatly facilitated not only access to data, but also data quality and use of data for program planning efforts. The Program coordinates the MCH Epidemiology workgroup that includes representatives of the MCH programs to discuss data needs, projects and policy.

State statutes relevant to Title V program authority and their impact on the Title V program
The Title V agency has authority under Statutory Regulatory Authority: Utah Code Ann. 26-1-18; 26-10-1,2, 4, 7. This statute outlines the authority of the state agency in provision of Title V services for Utah's population, in developing a state plan for maternal and child health services, including those with chronic health problems. The Division of Community and Family Health Services is the designated state Title V agency is responsible for meeting the federal Title V requirements.

The Utah Administrative Code provides access to medical records for public health surveillance activities, which allows the UDOH to utilize medical records for a variety of programs including the Perinatal Mortality Review Program to review maternal, infant and fetal deaths to identify public health issues amenable to prevention.
Hearing, Speech and Vision Services serves as the coordinator and central registry for State mandated newborn hearing screening under Utah's Newborn Hearing Screening Act, 26-10-6, 1998 General Session, Title 26, amended by Chapter 162. The database serves as the Utah registry for permanent hearing loss.

In 1965, statute (Section 26-10-6) was passed requiring that every newborn in Utah be tested for the presence of phenylketonuria (PKU) and other metabolic diseases, which may result in metal

retardation or brain damage. In January 2006, newborn screening will be expanded to include 32 new tests; therefore the rule for this statute will be updated. The Newborn Screening Program provides tracking and follow up of abnormal screens and diagnostic testing, and provides education to institutions of birth, medical home (providers), and families.
Related legislation or statutes, which impact Utah's Title V programs, include the ongoing challenge of addressing the needs of minors relative to sexuality and prevention of pregnancy, STDs, and HIV/AIDS. Current state law prohibits any government agency, including local health departments, from providing contraceptive information or services to minors without parental consent. The optimal situation is, obviously, parental involvement and the Utah Department of Health has worked, largely through the Title V-funded Abstinence-only Education Program, to promote increased parental knowledge, skills and abilities to discuss sexuality issues with their children in their homes.

State law requires state agencies and political subdivisions of the state (local health departments) to obtain written parental consent prior to provision of family planning information or services to unmarried minors (unless the unmarried minor is a Medicaid recipient). This requirement can present a significant barrier to providing family planning services to adolescents. During the 2001 Legislative Session, Utah legislators passed a bill prohibiting the state from applying for CDC funding related to HIV/AIDS Education due to misunderstanding of CDC requirements for use of the funding. This legislation limits the state's ability to promote reduced risk for HIV/AIDS among its student populations. The impact of this mandate has resulted in the loss of YRBS funding as well. The political climate regarding CDC funding is unfortunately so controversial that the State Office of Education has not sought federal funding to continue YRBS Surveillance. The Utah Department of Health now funds and coordinates this survey in collaboration with the State Office of Education and with support for data analysis by CDC. This change has resulted in the Division of Community and Family Health Services reallocating funding to support the YRBS process and analysis.

Oversight of sex education curriculum approval in the state was moved from the State Office of Education to the local school district. This shift in oversight may in fact result in a less rigorous review than might occur at the State Office of Education level. Educational funding was changed to school district block grants for certain funding components allowing school districts to determine allocation of the funds. Included in the block granting was school nursing, raising a concern that school districts will prioritize other issues higher than school nursing.
In March 2002, Secretary of Health and Human Services, Tommy Thompson, signed Utah's Primary Care Network (PCN), which had been approved by the 2002 Utah Legislature. Approximately 25,000 adults with incomes between 100% - 150% of FPL without insurance will be able to qualify and enroll for preventive health services under this plan. PCN will enable women who are enrolled in prenatal Medicaid to continue preventive health care coverage for primary preventive care, including family planning services if desired.

Violence and Injury Prevention Program's statutory authority derives from the Utah Department of Health's (UDOH) responsibility for health promotion and risk reduction as defined in the Utah Code 26-7-1: "The department shall identify the major risk factors contributing to injury, sickness, death, and disability within the state and where it determines that a need exists, educate the public regarding these risk factors, and the department may establish programs to reduce or eliminate these factors." The UDOH has also been empowered to "establish and operate programs necessary or desirable for the promotion or protection of the public health . . . or which may be necessary to ameliorate the major cause of injury." The local health departments also have authority to "conduct studies to identify injury problems, establish injury control systems, develop standards for the correction and prevention of future occurrences, and provide public information and instruction to special high risk groups".

During the 2005 Legislative Session, a number of bills were passed that impact maternal and child health care in the state, such as increasing the CHIP budget by $3.3 million, adding additional funding for the Center for Multicultural Health in the DOH, legalizing the practice of lay midwifery, including administration of some medications, with requirements for training. Bills that did not pass that impact health care included removing the asset test for pregnant women and children for Medicaid eligibility determination, and increasing dentists' reimbursement rates. Medicaid provider inflation increases

were approved.

B. AGENCY CAPACITY

Dr. Delavan, as the state Title V Director, is responsible for administration of the state Title V Block Grant. He accomplishes the administration through three Bureaus, all of which include programs funded through Title V or targeted to mothers, children or children with special health care needs. The state agency administers the grant through Department allocations of funding to programs, as well as through contracts with local health departments, community health centers, academic institutions and community agencies. Through this five year needs assessment and identification of the state priorities for mothers, children and children and youth with special health care needs, Dr. Delavan met with Bureau Directors, key staff, and advocates to determine how the state can best address the identified priorities, both through new state performance measures, planned activities and strategies to address the new state performance measures and reallocation of funding or resources to ensure that the priorities are addressed through appropriate planning and resource allocation. The details on the plans for the state priorities are included in the section on plans for state performance measures.

The Division of Community and Family Health Services consists of three Bureaus: Bureau of Children with Special Health Care Needs, the Bureau of Health Promotion, and the Bureau of Maternal and Child Health.

The MCH Bureau includes six programs: Reproductive Health, Child Adolescent and School Health, Immunizations, WIC, Oral Health, and Data Resources. The Reproductive Health, Child Adolescent and School Health, Oral Health and Data Resources programs are funded with Title V funding, while Immunizations and WIC are funded with CDC and USDA funding respectively.

The Bureau of Children with Special Health Care Needs consists of nine programs and is involved in the development of a system of care for CSHCN and their families throughout the state through infrastructure building, population screening, enabling services and direct services. There are nine programs within the Bureau: Newborn Blood Screening; Hearing, Speech and Vision Services; Genetics and Teratology; Early Intervention; Child Development Clinic; Neonatal Follow up Program; Adaptive Behavior and Learning Environment Clinic; Fostering Healthy Children; and the Technology Dependent Waiver Program. Other major initiatives and grants include: Medical Home; Autism Surveillance; Birth Defects Surveillance; Genetics Implementation Grant; the Child Health Advanced Record Management (CHARM) Initiative; itinerant multidisciplinary and specialty clinics throughout the rural areas of the state; collaboration with the Utah Leadership Education in Neurodevelopmental Disabilities Grant (ULEND); Early Hearing Detection and Intervention Grants; SSI outreach, information, and referral and transition to adulthood for youth with special needs. Many of these programs provide direct services to children and youth with special health care needs and their families.

The Bureau of Health Promotion consists of eleven programs, which work to promote health and wellness. The main areas covered by this Bureau include Tobacco, Cancer, Heart Disease and Stroke Prevention, Diabetes, Asthma, Arthritis, and Violence and Injury Prevention. Some of these programs develop strategies to address needs of the MCH population, such a youth tobacco prevention, youth suicide, promoting healthy lifestyles among elementary school children through nutrition and physical activity, to name a few.

The Department houses the Center of Multicultural Health, located in the Division of Community and Family Health Services. The Center staffs the Department's Ethnic Health Advisory Committee, which is comprised of representatives of the various ethnic and minority populations in the state. The Chair of the Ethnic Health Advisory Committee, Jesse Soriano, is himself Hispanic and participates in a number of advisory committees for the Division. For example, he is a conributing member of the MCH/CSHCN Advisory Committee. The Center is operated by a Hispanic individual who is adept at reaching out to the Hispanic populations in Utah, as well as other ethnic groups in the state.

The Data Resources Program has expanded capacity to address data needs of MCH and CSHCN programs to include a data analyst assigned to CSHCN and another dedicated to two programs, WIC and Immunizations. The latter position is jointly funded with USDA WIC Program and CDC Immunization Program funds, making for a strong partnership between the two programs. This expansion of capacity has greatly facilitated not only access to data, but also data quality and use of data for program planning efforts. The Program coordinates the MCH Epidemiology workgroup that includes representatives of the MCH programs to discuss data needs, projects and policy.

Describe State capacity to promote and protect the health of all mothers and children, including CYSHCN
Utah's Title V staff continually identifies areas and populations to seek out underserved MCH individuals in order to prioritize allocation of programs and resources. These on-going needs assessment activities aid us in determining the importance of competing factors upon the health service delivery environment in the State. Staff then develops plans, identifies resources, and develops interventions to help support the needed MCH services. After a standard review of all the necessary structures that need to be in place to support the delivery of health services to the MCH population, the important health status measures are evaluated and the resources are directed towards those populations.

The staff also uses their expertise to identify and weigh those competing factors, which may limit the degree of accessibility or availability of MCH services across the state. This work is done in conjunction with other community organizations and individuals who are interested in this effort largely through the MCH Advisory Committee input as well as staff involvement in various other committees, such as the Early Childhood Council, Covering Kids and Families Utah Project, etc. that raise issues of service need for MCH populations. Staff evaluates need and work towards refocusing efforts and resources as appropriate and available.
Satisfaction surveys of program participants are conducted annually by some programs, such as the VFC program, which surveys VFC providers to get input on the program, and WIC, which conducts an annual survey of participants to provide input on the program. The survey results are reviewed by program staff to refine program processes to provide better service.

Division program staff review and analyze data related to MCH populations and produce reports, fact sheets, abstracts for conferences and submit articles for publication. Several articles have been published in peer review journals, which have included Division staff as one or more of the authors of the publication. Utah staff usually submits one to three abstracts for the MCH Epidemiology Conference every year and often have the abstracts accepted for publication. As issues or concerns arise regarding health outcomes or access to health services, staff reviews the literature and conduct additional analysis to gain more understanding of the factors associated with the issue. For example, since Utah ranks low among states for adequate prenatal care, staff have analyzed birth certificate data, PRAMS data, and conducted focus groups to identify barriers to early entry. Once this analysis was completed, a strategy to address the barriers was developed and implemented. The "13 by 13" campaign was launched to promote the importance of getting into prenatal care by the 13th week and to get at least 13 prenatal care visits (assuming a term pregnancy). The campaign is currently being evaluated as to its effectiveness in getting more women into early prenatal care.

The Department of Health has been integrally involved in a state-level coalition targeted to early childhood systems development, the Early Childhood Council (ECC). The ECC is an evolution of an earlier committee that had been meeting for a number of years around systems development for early childhood services. The Council includes representation of the state agencies that provide services to this population of children, service providers, and advocacy organizations. The ECC is currently involved in defining the main goals for an integrated system and how the federal State Early Childhood Comprehensive Systems Grant can facilitate the work needed.

The Oral Health Program coordinates with the Utah Dental Association and the Utah Dental Hygienists Association to secure volunteers for activities like Sealant Saturdays and Head Start dental examinations. The State Dental Director has worked hard to establish a strong collaborative

relationship with the Utah Dental Association and has been very successful in engaging the Association leadership in oral health promotion and advocacy activities.

The MCH Bureau Director participates in a collaborative effort sponsored by the Intermountain Pediatric Society, Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) to improve health care to children with quality improvement (QI) efforts in pediatric practices. UPIQ partners with the IPS, the Utah Chapter of the American Academy of Pediatrics, include the University of Utah Department of Pediatrics, Intermountain Health Care, HealthInsight, Title V and Medicaid. The quality improvement process is achieved through Learning Collaboratives that bring practice teams together to lean the basics of QI principles and developing a plan to apply the process in the practices throughout a twelve-month period of time with support via conference calls, personal visits, materials, and so on.

The Bureau of Maternal and Child Health maintains contracts for MCH/CSHCN services with each of the 12 autonomous local health departments. The Department has been encouraging a shift in local health department service from direct service provision to a refocus on the core public health functions. The MCH Bureau is promoting this refocusing of public health efforts with the local health departments by changing the contracts with the LHDs to require a local needs assessment which includes a review of the local data for the MCH Performance and Outcome Measures, local capacity assessment, and prioritization of health care needs in MCH populations in their district. The expectation is that each local health department will work with its partners in the community to help determine local capacity, identify gaps and health needs of the MCH populations to then identify priority needs in the local district. The local health department staff and its partners then will review current services to determine if they correspond to the identified needs. The local health department may need to adjust resources, staff, programs, and funding to better address the identified needs in their communities if not reflected in the current service delivery. During FY06, all health departments will operate under the new contract requirements. State staff has provided data training and needs assessment process training and plans to provide technical assistance and consultation as needed by each of the local agencies. The local needs assessment process was modified from NACCHO's Making Strategic Decisions about Service Delivery: An Action Tool for Assessment and Transitioning. National Association of County and City Health Officials, 2002.

MCH and CSHCN Bureau staff participates in compliance and quality monitoring of Medicaid managed care organizations (MCOs), including periodic site visits to assess reproductive health services for women, EPSDT services and services for children with special health care needs. This process includes a review of the MCO's quality improvement plan, HEDIS data and other documentation as it relates to services for pregnant and postpartum women, children with special health care needs, and EPSDT services. Medicaid MCO contracts include the requirement of a satisfaction survey for special needs populations. CSHCN Bureau staff has been involved with the planning of two surveys completed in the past three years. The first Consumer Assessment of Health Plans Survey (CAHPS) survey sample was Medicaid disabled category children. Results were favorable and parents were generally satisfied with the availability of care and quality of services received through the MCOs, including specialty services. The initial CAHPS survey has been revised with the additional questions, but data are not yet available. CSHCN staff participates on Medicaid's Utilization Review and CHEC/EPSDT Expanded Services Committee, which meet weekly to determine coverage of non-covered services for Medicaid recipients, with the CSHCN Bureau Director, a pediatric neurologist, and the Bureau pediatric physical therapist having voting status.

Local school nurses work collaboratively with school district special education departments in a variety of activities, such as developing health care plans for children with special health care needs. School nurses provide the training and education to staff regarding special needs children and may designate responsibility for providing certain health services as appropriate under the current Nurse Practice Act and accompanying rules. Funding and staffing shortages contribute to the shortage of school nurses across the state.

The Division collaborates with many other programs and agencies in and outside the Department of

Health to improve services for mothers, children and children and youth with special health care needs. The Division is involved in a variety of coalitions, task forces, advisory committees that are sponsored by other programs, such as Medicaid, or other state agencies or community-based organizations. Some examples include: the Medical Care Advisory Committee (Medicaid); Child Care Licensing Advisory Committee (UDOH Bureau of Licensing); Child Abuse and Neglect Council (Department of Human Services); Covering Kids and Families Coalition (Voices for Utah Children); Utah Coalition to Promote Breastfeeding (WIC); Utah Perinatal Association, Utah Chapter of the March of Dimes, the Fetal Alcohol Syndrome Taskforce, Utah Chapter of National Family Voices, Oral Health Advisory Committee, Youth Suicide Prevention Task Force, Safe Kids Coalition, Utah's Transformation of Child and Adolescent Network (UT CAN -- mental health and substance abuse), to name just a few. In addition, Title V has developed strong relationships and collaborations with faculty at University of Utah Health Science Center -- Department of Pediatrics, Department of Obstetrics and Gynecology, Department of Family and Community Medicine; Utah State University -- Early Intervention Research Institute (EIRI) and Center for People with Disabilities; Utah Parent Information and Training Center, Utah Department of Workforce Services, Office of Child Care, Department of Human Services, Division of Children and Families, Division of Substance Abuse and Mental Health; and, State Office of Education (USOE).

As part of the FY06-10 Needs Assessment process, the Title V Director and key MCH and CSHCN staff reviewed the elements of CAST-5 to assess the Utah Title V agency's capacity needs. Overall Utah's Title V agency has much capacity and the elements that were noted as needing improvement really only reflect the desire to development these elements to a higher level. The elements are in place, but barrier may prevent staff from accomplishing as much as they would like. Overall, the agency has capacity for 21 of the 28 elements, with the remaining 7 elements needing improvement or further development. The seven elements included: 1) Authority and funding sufficient for functioning at the desired level of performance -- the challenges in this element include: inability to create new positions to address capacity needs due to legislative restrictions; restrictions on applying for grant funds if new positions are needed to carryout the grant; and limited state funds for grants that require non-federal match. 2) Mechanisms for accountability and quality improvement -- we have informal processes in place for quality improvement for many programs, but limited ability to implement quality improvement with contractors, such as local health departments. Programs providing direct services tend not to be receptive to quality improvement as it interferes with service provision. 3) Formal protocols and guidance for all aspects of assessment, planning and evaluation cycle -- this element is one that we need to focus more on and develop staff capacity. 4) Adequate data infrastructure -- We have strong data support, but capacity needs to be built to better support data needs of the state Title V agency in its work 5) Other relevant state agencies -- While the UDOH has strong collaborative relationships with many state agencies, the State Office of Education has been very difficult to engage in collaborative initiatives. With a new Executive Director, perhaps this will change for the better. 6) Businesses -- this is an area that the Division of Community and Family Health has embarked on to a certain degree, but needs further development. 7) Ability to influence policy making process -- The Department has the ability to influence policymakers to the degree that is within the boundaries of state government roles and the Governor's agenda. The new Executive Director of the Department of Health has vast experience in government nationally which will greatly benefit public health and Title V in the state as he works to overcome challenges we face.

State's capacity to provide:
Preventive and primary care services for pregnant women, mothers, and infants
Reproductive health services, in some degree, are offered by each of the twelve local health departments (LHDs) with 11 local health departments providing PE screening. Two urban LHDs (Salt Lake Valley and Weber/Morgan Health Departments) are sites for direct prenatal services provided by the University of Utah Health Sciences Center and the Midtown Community Health Center Family Practice, respectively.

During the past few years, the Presumptive Eligibility (PE) system has become a barrier to prenatal care in Salt Lake due to restrictions on PE determinations for private provider clients by the Qualified Provider sites. The Division initiated "Baby Your Baby by Phone" for women to obtain PE on the

phone, which has been effective in getting eligible women on PE to access prenatal care. The Division is working with a contractor to develop an online PE application process in conjunction with Medicaid and WIC.

Eleven LHDs provide presumptive eligibility determination, and 10 obtain a prenatal history, including obstetrical, nutritional, socioeconomic, and a brief psychosocial review. Risk factors are identified and a plan of action developed. The mother is assisted in finding a provider and referrals to other resources are made based on her need. Availability of enhanced prenatal services varies among the health districts and even among an individual health district's sites. Federal MCH funding has been allocated to two agencies, Salt Lake Valley Health Department and the Community Health Centers, Inc., to support prenatal services to uninsured women in Salt Lake City. Depending on a client's payer, all or a portion of the enhanced prenatal services (perinatal care coordination and pre/postnatal home visiting, nutritional counseling, psychosocial counseling and group pre/postnatal education) is available directly or by referral to other agencies.

Complete family planning services are only available in eight local health districts. Two other districts provide partial services by obtaining medical histories, providing education on contraceptive options and by subsidizing oral contraceptives and physical examinations by private providers. Another district provides only Depo-Provera onsite but subsidizes oral contraceptives for private providers' low-income women. One rural health district has no publicly funded family planning services available in its jurisdiction.

The University of Utah Health Sciences Center has a comprehensive program for pregnant teens and their young children in Salt Lake City, partially funded by MCH Block Grant monies, which includes PE, prenatal care, WIC, and intensive follow-up for the mothers to prevent rapid repeat pregnancies, and well child care for infants.
Low cost reproductive health services on a sliding fee scale are available in Wasatch Front and rural community health centers. Family planning services are available on a sliding fee scale through Planned Parenthood Association of Utah (PPAU), the state Title X agency. However, in the rural areas of the state, family planning services are not readily available through local health departments or PPAU clinics. MCH has developed a strong relationship with PPAU with much collaboration between the two agencies on a number of common issues. PPAU is currently collaborating with two LHDs to provide emergency contraception for qualifying women.

Comprehensive health care for homeless individuals is available through a Salt Lake clinic, including PE and family planning through a contract with PPAU. Centro de Buena Salud, a migrant health center in northern Utah, provides PE screening and prenatal care to eligible women. Prenatal care and family planning services are available to Native American women in the Salt Lake City area through the Indian Walk-In Center via contracts with Community Health Centers, Inc.; for the Southeastern area of Utah via the Utah Navajo Health Systems, Inc., and through the Indian Health Service facility on the Fort Duchesne Ute Reservation in northeast Utah. Women enrolled in the Shoshone Band in Box Elder County may receive reproductive health services via contract with local providers.

Two programs in the Bureau of Children with Special Health Care Needs address newborns: the Newborn Screening Program and the Hearing, Speech and Vision Services (HSVS) Program. The Newborn Screening Program oversees the state newborn blood screening and ensures follow-up for those infants whose tests were positive. The HSVS Program oversees and supports the newborn hearing screening program by maintaining a comprehensive (child) database, aggressive tracking of newborns, a multidisciplinary advisory committee that reviews and provides guidance, and a system that provides an annual evaluation of the state's newborn hearing screening and follow-up performance.

The Tobacco Control and Prevention Program has worked with the Reproductive Health Program and Medicaid to promote tobacco cessation among pregnant women throughout the state. Utah's Medicaid prenatal benefits include counseling and/or appropriate pharmaceuticals to assist pregnant

women in smoking cessation efforts.

Preventive and primary care services for children
The HSVS Program oversees the hospital newborn screening program and statewide consultation, education, and clinical services in the areas of communicative disorders (speech-language development and hearing) and preschool vision screening.

Secondary disabilities prevention is a critical endeavor and birth defect surveillance programs have a unique opportunity to identify infants and provide information for families regarding available services. When a child is diagnosed with a structural birth defect, UBDN staff members are available to provide information about a particular defect, referral for health care, social or financial information. At the delivery hospital each mother is given a brochure about newborn metabolic screening, which includes information about the UBDN with the local and toll-free telephone number. UBDN has a web site that provides all necessary contact information (email, telephone, fax) for UBDN staff, as well as local and national links to other informative web sites. Families or health care providers may contact the UBDN Director or other staff members at any time, an approach that represents a passive outreach activity. In the future, the UBDN would like to take a more active approach, making certain that all families that qualify for a particular service obtain the necessary assistance to help their child. Linking families with other families that have children with similar birth defects is also a need repeated in focus groups and women who contact the UBDN. The UBDN is projected to be rolled into the CHARM (Child Health Assessment Record Management) project during 2005. This integration of data sets will facilitate children getting into services provided by the UDOH and other agencies as well as notifying community health care providers of needs associated with the child's particular birth defect (i.e., infants with Down Syndrome should have a echocardiogram to rule out cardiovascular disease).

Although all local health departments and community health centers are Vaccine for Children (VFC) providers, there are areas in the state with a shortage of VFC providers. The Immunization Program has worked diligently to increase the number of VFC provider sites by changing Medicaid provider enrollment to include automatic VFC provider enrollment unless a provider opts out of this program. The Program launched a statewide effort to increase the number of private providers enrolling in the VFC Program. This concerted effort to increase private provider enrollment in VFC resulted in an increase to 291 VFC providers in 2004.

The dental services indicator continues to be concerning since children on Medicaid have access to dental care, however, we do know that Medicaid reimbursement rates for dental care are a major barrier to dentists' willingness to provide care to children enrolled in Medicaid. The State has been served with notice of a lawsuit regarding low reimbursement rates for dental care. The Oral Health Program works closely with Medicaid to convey issues that the dental community is facing with the Medicaid program.

School nurses are employed either directly by a school district or by a local health department, which contracts with a school district to provide school nursing services. They provide a variety of services, including the development of health care plans for children with special health care needs to assist school staff in working with these children. In accordance with the Utah Nurse Practice Act and accompanying rules, school nurses may delegate certain tasks to school staff to ensure children receive the proper care they need during school hours. School nurses provide the training and evaluation for these delegated tasks, while maintaining ultimate responsibility for the outcome. School nurses also provide health teaching, staff wellness, and consultation in developing school health policies. They also serve as a liaison between school personnel, family, community, and health care providers.

The Violence and Injury Prevention Program interventions have focused on bicycle and pedestrian safety. Bicycle helmets are an effective safety device to reduce injury and death. It is estimated that if every Utah bicyclist used a helmet, health care cost savings would total $19 million a year. Interventions for children have also targeted other aspects of bicycle and pedestrian safety

Services for children and youth with special health care needs
Primary care services for youth and young adults with special health care needs are not readily available in Utah. Advances in health care have allowed children with complex conditions to live longer and more productive lives, however, adult primary care providers are often not familiar with the conditions and support needed for rare or complicated conditions. Additionally, routine preventive dental care for children, youth and adults with special health care needs is especially difficult to access. Some of the barriers include: many dentists are reluctant and/or not trained to treat children and youth with disabilities in the traditional office setting; many children and youth with disabilities are Medicaid recipients and many dentists will not take Medicaid patients due to poor reimbursement.

C. ORGANIZATIONAL STRUCTURE

In January 2005, Jon M. Huntsman, Jr. became the 16th Governor of Utah. Governor Huntsman appointed a new Executive Director for the Department of Health, David N. Sundwall who comes to the Department with extensive experience in the federal and national arena. The Department of Health is a cabinet-level position in state government, thus Dr. Sundwall reports directly to Governor Huntsman.

Utah's Title V programs are administered by the Division of Community and Family Health Services of the Utah Department of Health, under the direction of George W. Delavan, M.D., a pediatrician with many years experience in public health and children with special health care needs. Dr. Delavan reports to the Deputy Director of the Department, Richard Melton, Dr.P.H. Dr. Delavan oversees the Title V programs and other programs that address the health of Utah's population. The Division is the lead agency for Individuals with Disabilities Education Act (IDEA), which is the state Part C program and the State's Immunization and WIC Programs. The Division website is : http://www.health.utah.gov/cfhs.

Organizational charts have been attached to display the organizational structure of the Department of Health and its programs. Of note, the State Medicaid agency, the Division of Health Care Financing, is housed in the Department of Health, which facilitates the strong collaboration between Medicaid and Title V.
The Title V programs are housed in two of three Bureaus, the MCH and the CSHCN Bureaus. The third Bureau, Health Promotion, includes other programs may not that address the needs of mothers and children, although not generally funded with Title V.

The Bureau of Children with Special Health Care Needs includes eight programs and the state Part C program, Baby Watch/Early Intervention. The Bureau is headed by Vera Frances Tait, M.D., a pediatric neurologist with more than 17 years of experience in rehabilitation. Holly Balken, Assistant Bureau Director, is a Master's prepared nurse with 30 years of experience.
http://health.utah.gov/cshcn/

The MCH Bureau includes six programs that specifically focus on mothers and children. The MCH Bureau is headed by Nan Streeter, a master's prepared nurse who brings more than thirty years of experience to this position. http://www.health.utah.gov/cfhs/mch/

Programs that are funded by Title V
The program descriptions outlined here provide the services of preventive and primary care to pregnant women, mothers, infants, and children as well as services for children and youth with special health care needs.

The Birth Defects and Genetics Program houses three projects: 1) The Pregnancy RiskLine which provides accurate and current information and counseling about possible effects of maternal exposure to medications, drugs, chemicals, infections, and other diseases on a fetus and breastfed infant. This free information to improve the pregnancy outcome is provided by telephone through a toll-free line

and in written follow-up to callers. 2) The Utah Birth Defect Network identifies infants born with major birth defects to determine prevalence, assess demographic distribution and to provide families with education and referral to appropriate services. 3) The Utah
Genetics Project oversees the integration of genetics and genomics into public health practice. Websites include: http://www.health.utah.gov/cshcn/pregnancyriskline/ and http://health.utah.gov/birthdefect/

The Child Adolescent and School Health Program assures services to Utah's early childhood, school and adolescent populations by providing consultation to local health departments, schools, and others. The program oversees the Head Start-State Collaboration Project grant; the Prenatal-5 Nurse Home Visiting Program, the Sudden Infant Death Syndrome Program, the Healthy Child Care America grant, the State Early Childhood Comprehensive Systems grant, the Abstinence Only Education grant, school and adolescent health. Website is http://www.health.utah.gov/cash/

Child Development Clinic provides multidisciplinary clinical services for children up to five years of age with special health care needs. The program offers consultative and case management services for children with multiple disabilities up to age 18 years. The Utah Registry of Autism and Development Disabilities collaborates with the Centers of Disease Control and Prevention to conduct an epidemiological study to determine the prevalence rates of Autism Spectrum Disorders and mental retardation in Utah. http://health.utah.gov/cshcn/cdc/

Data Resources Program provides analytic resources and statistical expertise for assessing the health status of the population and planning and evaluating maternal and child health services in Utah. The MCH Epidemiologist heads this program. Analytic support is also provided to CYSHCN programs.

Hearing, Speech, and Vision Services (HSVS) Program provides statewide screening, evaluation, and referral of infants and children with hearing, speech, and/or vision problems. Facilities are located in Salt Lake City, Ogden, Price, and Cedar City. HSVS is responsible for management of the Newborn Hearing Screening database that includes the screening and follow-up results of the state's newborns as well as the coordination (including training) of the EHDI Program.
http://health.utah.gov/cshcn/hsvs/

The Neonatal Follow-up Program offers multidisciplinary services to very low birth weight and prematurely born babies statewide. The program provides periodic screening of sensory, neuro-developmental and general health. A summary report is shared with child's primary physician, early intervention service and respective newborn intensive care unit. All summary reports are entered into a database. Trends and outcome are monitored. http://health.utah.gov/nfp/

Oral Health Program promotes prevention to reduce dental decay and other oral diseases and increase access to oral health care for pregnant women, mothers, infants, and children including those with special health care needs. The program provides technical assistance to local health departments and others in the community. The State Dental Director is housed in the program.
http://health.utah.gov/oralhealth/

The Reproductive Health Program (RHP) comprises five components: prenatal to improve access to care through Presumptive Eligibility and enhanced prenatal Medicaid services; family planning to assure access to services in underserved areas; Perinatal Mortality Review to review fetal and infant deaths, and deaths of women who have recently delivered to develop strategies to prevent future deaths. (www.utahrhp.org).

School Age and Specialty Services Program improves care delivery to school-aged children who are at risk for or identified with complex behavioral or learning disabilities or chronic physically disabling conditions by the

Adaptive, Behavioral and Learning Environment (ABLE) clinic. The team works with families, schools

and agencies and provides multidisciplinary diagnostic evaluations and school-based care coordination for services. The program also oversees Specialty Services contracts with the University of Utah and private providers for provision of specialty care to children in Neurology, Genetics, Pediatrics, Orthopedics and Ophthalmology.

Violence and Injury Prevention Program (VIPP) works to reduce injury in the state of Utah, with a specific focus on youth injury prevention. The program has several components: school injury prevention, youth suicide prevention, pedestrian and bicycle safety, motor vehicle occupant protection, Utah Safe Kids Coalition, and, child fatality and domestic violence fatality reviews. In addition, the program works to prevent falls, rape and sexual assault. http://www.health.utah.gov/vipp/

Other Programs that are administered by the Title V agency with non-Title V funding: BabyWatch/Early Intervention Program (BWEIP) provides early and developmental interventions statewide for young children with developmental delays and/or disabilities from birth to age three. Children with a delay in one or more of the following areas qualify for services: cognitive, motor, language/speech, psychosocial development, self-help, hearing, vision, or physical development/health. Services include multi-disciplinary evaluation and assessment; service coordination; specialty and therapy services such as nursing, physical, occupational and speech therapy, special instruction, family support and related services that build on family strengths and child potential. Services are available statewide through local agencies. Services are available to families on a sliding fee. http://www.utahbabywatch.org/

Baby Your Baby Program educates families about the importance of early and regular prenatal and well-child care and where families may obtain services. The program conducts television and radio public service announcements, the Baby Your Baby Hotline and provides free educational materials such as the Baby Your Baby Health Keepsake, newsletters, and other incentives. http://www.babyyourbaby.org/

Community-Based Services Program (CBS) provides care coordination to a target population of 120 technology dependent children statewide through Medicaid's Travis C. Waiver. This program also includes the Medical Home staff and the CSHCN Parent Advocate Coordinator.

Fostering Healthy Children Program (FHCP) assists the Division of Children and Family Services (DCFS), the state child welfare agency, in meeting the health care needs of children in foster care by co-locating nurses with DCFS case workers and providing administrative medical case management. for almost 4000 children through the "SAFE" information, the Statewide Automated Child Welfare System. http://www.health.utah.gov/cshcn/fhcp/

Heart Disease and Stroke Prevention Program targets all ages, but specifically has developed a school-based program called Gold Medal Schools which promotes healthy eating and physical activity.

Immunization Program is funded through CDC grant funding. The Program assures that Utah's children are adequately immunized and assures that the components of a statewide immunization program as required by CDC are addressed. http://www.immunize-utah.org/

Newborn Screening Program provides a statewide system for early identification and referral of newborns with any of four disorders (phenylketonuria, galactosemia, congenital hypothroidism, and hemoglobinopathies) that can produce mental retardation or death if not treated early. Hospitals are charged a fee for the testing kit which funds the lab testing and nursing follow up of identified children. By January 2006, the program will incorporate screening for Congenital Adrenal Hyperplasia, Biotinidase and disorders identified through tandem mass screening to the mandated newborn blood screening panel.http://www.health.utah.gov/newbornscreening/

Tobacco Prevention and Control Program provides technical expertise and coordination at the state and community level to prevent and reduce tobacco use in youth and adults including pregnant

women through educational and cessation programs and policy development. Efforts to enhance tobacco-free policies include increasing the number of tobacco-free outdoor venues frequented by youth (parks, arenas, rodeos, etc.) and supporting a change in Utah's Indoor Clean Air Act to protect employees of bars and clubs from workplace exposure to secondhand smoke.
http://www.tobaccofreeutah.org/

WIC (Women, Infants and Children) is the USDA-funded supplemental food and nutrition program. WIC provides evaluation of nutritional risk, nutrition education, and food vouchers to pregnant and breastfeeding women, and children up to age 5 who meet program eligibility criteria.
http://health.utah.gov/wic/

Other programs that may include strategies that impact mothers and children include Asthma, Arthritis, Cancer, Diabetes Prevention and Control and Genomics.

D. OTHER MCH CAPACITY

George W. Delavan, M.D., who heads the Division of Community and Family Health Services, is the State Title V Director. Dr. Delavan is a board-certified pediatrician with expertise in Children with Special Health Care Needs. CFHS is organized into three bureaus, comprising twenty-five programs. Each program reports to one of four Bureau Directors or Assistant Bureau Director.

The senior level management staff in charge of this entire Division brings a wealth of experience and a depth of training to their respective program areas. They have the opportunity to lead an expert staff of approximately 300 individuals in carrying out their mission to improve the health of Utah's residents.

Division program planning and evaluation occur at the program level with support from Division data resources as well as Department-level data analytical resources. The Division has dedicated staff that provides data analysis to aid the Division Director, Program Managers and Bureau Directors in planning and evaluation processes. In December 2002, after several years of searching for an appropriate candidate, the Division reorganized the Division-level Data Resources Program to a Bureau of Maternal and Child Health program to better support the data needs of the Bureau. This change resulted in filling the position of MCH Epidemiologist with the Manager of the Data Resources Program who has proven to be very skilled and adept for the position.
Data capacity is strong in the Utah Department of Health (UDOH) including in the Division of Community and Family Health Services. The Department's Center for Health Data provides a great deal of support for Title V data needs by offering direct access to vital records, hospital discharge data, and a variety of health status and health care data. One of the major strengths in the data infrastructure of the UDOH is the online Indicator-Based Information Query System (IBIS). This system acts as the primary point of data access and houses birth, death, hospital discharge, BRFSS, Health Status Survey, PRAMS, Cancer Registry, injury and other public health data. Division staff is very familiar with this system and utilizes it on a daily basis, allowing more timely access to data. Data Resources and MCH PRAMS staff collaborates with various UDOH programs and has established a network (MCH Epi Group) to share data issues related to the MCH populations. MCH staff continues to partner with Medicaid in order to link birth and Medicaid eligibility data to assess birth outcomes among Medicaid women. Due to the recent development of Medicaid Data Warehouse, accessing eligibility and claims data has been more easily attainable.

Since the data capacity of the Department is strong, the Division has successfully submitted abstracts to the Annual MCH Epidemiology Meetings, which have resulted in several presentations and poster sessions at the meetings for a number of successive years. Staff in the other Bureaus of the Division has also submitted abstracts and presented at other national meetings.

Number and location (central and out-stationed) of staff that work on Title V programs
The Division members staff are housed in two buildings in Salt Lake City, the main Department of

Health Building, the Martha Hughes Cannon Building, and the clinical services building, the Center for Children with Special Health Care Needs. The Center for Children with Special Health Care Needs is conveniently located within walking distance of Primary Children's Medical Center (PCMC) and the University of Utah Health Sciences Center (UUHSC) and within one mile of Utah's Shriners Hospital for Children.

The majority of CSHCN staff is based in the Salt Lake City office. Some Salt Lake City based staff provide services in outlying areas of the state through traveling clinics, while other state staff are stationed outside of Salt Lake to provide services in local communities outside the Salt Lake area. For example, there are twenty-seven nurses working in the Fostering Healthy Children Program throughout various parts of the state. The Hearing Speech and Vision Program, in addition to the Salt Lake staff, has 4 employees out stationed in the southern part of the state (Cedar City) the eastern part of the state (Price) and in Ogden. These staff members include three audiologists, a speech pathologist and two support staff. The CSHCN pediatric clinics have 3 employees who are out stationed in Ogden in addition to contract staff in 8 rural Local Health Department satellite sites that support the itinerant multidisciplinary clinics. These satellite offices are staffed by a total of 18 RN's and health program specialists. The Utah Collaborative Medical Home project has worked with pediatric and family practice providers to enhance their capacity to provide medical homes for children with special needs. Trained Medical Home teams (physician, nurse and parent advocate) are now established in Montezuma Creek, Orem, Salt Lake (4), Ogden (2) and Logan. Ongoing technical assistance and support is provided to these teams through CSHCN and University of Utah staff, as well as through the MedHome Portal website.

Number and role of parents of special needs children and youth on staff
The CSHCN Bureau has hired the Director for the Utah Chapter of Family Voices (UFV), who is the parent of four special health care needs children. She has over 19 years of experience in parent self-advocacy training through the Utah Parent Information and Training Center (UPC) and she has been very active in the Utah Medical Care Advisory Council for Medicaid, the Utah Legislative Coalition for People with Disabilities and the ULEND project. She has been integrally involved with the establishment of Utah Collaborative Medical Home Project and has provided support to the parent advocates in the individual Medical Home practices across the state. There are nine trained Family Advocates in the Utah Collaborative Medical Home Project. The Bureau also contracts with LINCS to provide parent support and advocacy to parents of patients who are served through the rural traveling clinics. Through LINCS, there are trained family advocates in each of the eight rural CSHCN Satellite areas.
CSHCN is also collaborating with Utah Family Voices (UFV) and the Utah Parent Information and Training Center (UPC) in the implementation of a Center for Medicaid and Medicare Services (CMS) grant, awarded to UPC and UFV in October 2004. This three-year project is housed at the UPC and is designed to establish a Family-to-Family Center. CSHCN has dedicated $50,000 of MCH funding to enhance family-to-family activities and support development of a family database. Through this grant two Family Health Partners have been hired and trained to assist in family-to-family health information and education. Also this funding will be used to reimburse families for their consultation and involvement in development of materials for various family-to-family projects, such as the CMS Family-to-Family project, the Utah Collaborative Medical Home project, the ULEND project and medical residency training. This funding will also set up a toll free information and referral line, staffed by trained parents.
Through the Family to Family grant, a statewide Family Advisory Committee will be established which will include families of CYSHCN, a young adult with special needs, key CSHCN Bureau staff, private providers and a representative from Medicaid. The Utah Collaborative Medical Home Project will collaborate in the establishment of this committee. The stakeholders in this committee will insure that the Family-to-Family Center project is effective in addressing the needs of Utah families of children and youth with special health care needs.
Utah Family Voices received a Health Insurance and Financing Technical Assistance Initiative through the Maternal Child Health Bureau. Through this technical assistance initiative, UFV will conduct focus groups of parents to ascertain the issues facing parents of CSHCN related to health care insurance and funding. The results will be used to develop a parent focused tool kit for the

MedHome Portal website. The findings will also be published for key stakeholders to use in outreach efforts and policy development.

The Utah Family Voices Director is involved with the Family Advisory Committee through Primary Children's Medical Center, which is Utah's tertiary care pediatric facility. Work through this committee will help to develop best practice policies for providing family centered care through this facility. Additionally, issues of discharge planning and linking hospital care to community services for children and youth with special health care needs are being addressed. This advisory committee has also been established as a forum in which families of children and youth with special health care needs can have issues and problems related to hospital care resolved.
The toll-free Baby Your Baby Hotline provides information and referrals on providers and/or financial assistance for prenatal care, family planning, well childcare, nutrition services, or other related services. The hotline staff collaborates well with community resources to ensure that information is current. The hotline is viewed as a valuable resource for both callers and community resources.

E. STATE AGENCY COORDINATION

The Utah Title V agency coordinates efforts with numerous other Department of Health programs, other state agencies, private not-for-profit organizations and community-based agencies.

Human Services Agencies
The Division of Community and Family Health Services coordinates efforts for the MCH/CSHCN populations with many other agencies in the state. The Division of Community and Family Health Services works closely with the Department of Human Services, which serves the maternal and child population statewide related to child welfare, mental health and substance abuse.

Department of Health staff has sought to strengthen the relationship with the Department of Human Services Division of Substance Abuse and Mental Health (DSAMH) through regular meetings to discuss issues and opportunities for collaboration. The DSAMH received a five-year grant UT CAN -- Utah's Transformation of Children and Adolescent Network to improve the mental health service system infrastructure for children throughout Utah. Title V staff participate on the Steering Committee and subcommittees. The Bureau of CSHCN is collaborating with this effort especially through its Medical Home initiatives, including the MedHome Portal website.
CSHCN Bureau staff participates on the Health Care Consortium Council for the Division of Child and Family Services (DCFS), Utah's child welfare agency, which advises the DCFS Board on health issues for children in their system. The Fostering Healthy Children Program (FHCP) co-locates CSHCN nurses with DCFS caseworkers to assist them in coordinating health care. Since all foster children in Utah are covered through Medicaid, FHCP collaborates closely with Medicaid to ensure that services are accessible for these children.
Two Division representatives sit on the DCFS Child Abuse and Neglect Council, and an interagency group, Utah Prevention, to address substance use and other issues among youth. Multiple Division representatives are on an interagency group to address youth transition issues.

The Baby Watch/Early Intervention (BWEI) Program works with DCFS to develop policy and procedures for the Child Abuse Prevention Treatment Act (CAPTA) requirements for referral of children with substantiated abuse and neglect to BWEI. New DCFS procedures for child protective personnel will require developmental screening of children birth to three at the initial home visit. Children who show potential problems will be referred to BWEI. Local BWEI agencies will partner with local DCFS personnel to train on the developmental screening tool and design referral procedures for children suspected of a developmental delay. BWEI and DCFS received a $10,000 grant from the National Association of State Directors of Special Education to support this work.
The Interagency Coordinating Council (ICC) provides advice to BWEI. The ICC membership, representing statewide early childhood services community, is comprised of 25 members. The state is able to bring together clinical staff, political appointees, parents of special needs children, and administrative representatives of various agencies or providers such as mental health, human services, education, Department of Insurance, Head Start, Workforce Services, Division of Services

for People with Disabilities, physicians and representatives from contract Early Intervention providers. The ICC provides a broad vision of the service system based upon the participation and contributions of relevant providers and consumers.

Title V staff work collaboratively with other state agencies, such as the Office of Education, Juvenile Justice, School for the Deaf and Blind, the Office of the Courts, Utah Highway Safety Office, to name a few to improve the health of mothers, children and children and youth with special needs. CSHCN Bureau and the Office of Students at Risk (SARS), the state special education program, enjoy a strong working relationship and have collaborated on a number of projects, such as Medical Home and the development of several Learning Modules on the MedHome Portal. A SARS staff member sits on the MCH Advisory Committee and the Medical Home Advisory Committee. CSHCN Bureau and SARS have worked together on the Utah Registry for Autism and Developmental Delays (URADD) grant.

Medicaid
Title V enjoys a strong relationship with Medicaid, helped by the fact that Medicaid is housed in the Department, thus the two are "sister" Divisions. Utah's CHIP Program, a stand-alone program, is administered by Medicaid. The Division has a MOA with Medicaid that promotes collaboration between the two agencies. The Division works closely with Medicaid staff on EPSDT and other Medicaid administered programs. Medicaid provides match for a number of programs that serve the Medicaid populations, such as Baby Your Baby outreach, PRAMS, etc. Medicaid developed targeted case management (TCM) for children up to age four in collaboration with Title V staff.

Title V staff participate in quality assurance review of the managed care organizations or PPO that provide services for the Medicaid population. Reproductive health, child health and CSHCN staff participates in reviews with Medicaid to ensure that MCH/CSHCN services are appropriate and comprehensive. These programs also work closely with Medicaid to certify smoking cessation interventions for pregnant Medicaid participants; provide case management to a subset of high-risk pregnant Medicaid women; and to ensure information for, outreach to and access for Medicaid eligible children and youth with special health care needs and their families. Two Medicaid eligibility workers at the CSHCN clinics work with the Travis C. Waiver Program, clinics and other Medicaid staff at two adjacent tertiary care facilities. CSHCN staff serves as consultants to the Medicaid Prior Authorization Committee.

Title V staff collaborate with Medicaid on a grant-funded project, ABCD II, which promotes social emotional screening of young children and assessment of postpartum depression. MCH Bureau staff has worked with Medicaid on a family planning waiver that the state will submit to the CMS in the near future.
The Oral Health Program has well-established relationships with Medicaid and CHIP to improve accessibility to Medicaid/CHIP dental services. Program staff collaborated in defining a basic scope of CHIP dental benefits; ensuring that CHIP children can be seen by "any willing provider"; and, expanding CHEC (EPSDT) outreach programs for case management for children needing dental services. CSHCN Bureau staff participates in Medicaid's Utilization Review and CHEC Expanded Services Committee to determine coverage of non-covered services for Medicaid recipients. The CSHCN Bureau Director has voting status on the committee and the Bureau's Physical Therapy supervisor is a consultant to the committee.

SSI, DDS and Vocation Rehabilitation
The SSI Specialist position in CSHCN, established over ten years ago, continues to work with the Office of Disability Determination Services (DDS) that evaluates disability claims for SSI eligibility by reviewing DDS claims and providing outreach and referral for potentially Medicaid eligible children. The specialist provides information, referral and enabling services to families having difficulty accessing or utilizing services, such as Utah Legal Services, Disability Law Center or DDS. CSHCN Bureau staff participates on the DDS Advisory Committee that has fostered cross training of CSHCN Bureau and DDS staff.

CSHCN has a staff member on the Traumatic Brain Injury Advisory Committee, housed in the Vocational Rehabilitation office. A member of Voc Rehab sits on the CSHCN Medical Home Advisory Council. The MedHome Portal Website has worked with Vocational Rehabilitation office advisors to develop the transition to adulthood module. CSHCN staff members are active in the Utah Center for Assistive Technology Center under Vocational Rehabilitation on advisory boards and in coordinating direct care for individuals with disabilities.

Family Leadership and Support Programs
CSHCN has hired the Utah Family Voices Director to provide consultation and support to CSHCN programs and families, and to infuse and enhance family-centered values into CSHCN Bureau programs and initiatives. The Family Voices Director works closely with the Utah Parent and Information Center in teaching and mentoring other families of children and youth with special health care needs. CSHCN also contracts with the Liaison for Individuals Needing Coordinated Services (LINCS) to provide direct services.
Local public health agencies

The relationship between the local health departments (LHDs) and the MCH/CSHCN programs has been strong, although in previous Department administrations it has been strained due to the shift of services to managed care organizations and tensions over limited funding. Dr. Sundwall, the Department's Executive Director, has made a commitment to working with local health departments. He appointed a Department liaison, a position that had been previously abolished. The Department plans to work with the local health departments to develop a state public health plan.

Each local health department determines the MCH services it will provide based on resources, community priorities, and need. Each district receives MCH block grant funds for services, although each varies on which services it provides. MCH program staff works closely with local health department (LHD) staff. To support the current contract requirements for MCH for a community needs assessment, MCH staff provide technical assistance and consultation as needed. The Bureau of Children with Special Health Care Needs contracts with several LHDs to coordinate clinical services for the itinerant clinics in rural areas. State staff meets with local health officers and nursing directors during their quarterly meetings as needed or requested. Representatives of the local health officer association and the local nursing director association participate in various Division advisory committees or task forces to ensure their input and support.

The Oral Health Program has been working with local health departments to improve oral health awareness by awarding small grants funded by a HRSA grant to support local oral health activities.

Federally qualified health centers and state primary care association
While the relationship with community health centers is positive and collegial, it needs to be nurtured more since they are critical primary care providers for a large population of uninsured individuals. Division staff has a stronger more collaborative relationship with the State Primary Care Association, State Primary Care Organization and the community health centers by invitations to sit on Division advisory committees, etc. The Executive Director of the Association of Utah Community Health (AUCH), Utah's Primary Care Association, sits on the MCH/CSHCN Advisory Committee, and others.

The Immunization Program contracts with AUCH to increase immunization rates among populations served by community health centers. The contract relationship has grown over the past five years and is a strong collaborative effort. A small contract of MCH dollars is given to the Salt Lake community health centers for prenatal care for uninsured women. The Oral Health Program works with AUCH to provide technical assistance to their dental clinics and encourage the addition of dental clinics in other community health centers.

CSHCN included the Navajo Reservation-based Montezuma Creek Community Health Center in the initial 2001 Utah Medical Home project. The Family Practice provider team of participated in the Medical Home training project. Although the grant has ended, this practice team continues to be an active Medical Home site having added four members to their team.

Tertiary care facilities
The Division has effective relationships with the tertiary facilities in the state, five perinatal centers and two children's centers. The University of Utah Health Sciences Center, a tertiary perinatal center works closely with MCH Bureau staff. University faculty are involved in a number of Department efforts to improve health of mothers and children.

Primary Childrens Medical Center (PCMC), one of two children's hospitals in the state, works closely with the Bureau of Children and Youth with Special Health Care Needs to coordinate services for children with special needs. PCMC physicians participate in the Department's Child Fatality Review Committee to identify those deaths that possibly are preventable.

The Utah Collaborative Medical Home Project, a collaborative effort with the University of Utah Department of Pediatrics, Utah State University, Medicaid and Utah Family Voices, provides outreach and support to medical homes statewide for children with special health care needs. The project is guided by an advisory committee of private pediatric and family practice physicians, families, allied health professionals and other partners, such as education, vocational rehabilitation and Medicaid. The PCMC strategic plan for children and youth with special health care needs includes support of Medical Homes. The CSHCN Director serves on the PCMC Pediatric Education Services Continuing Medical Education Committee, which credentials physician CME credits and identifies topics for Pediatric Grand Rounds. The CSHCN Director is involved in University of Utah and PCMC based health services research committee. The CSHCN Family Advocate Coordinator serves on the PCMC Family Advisory Committee.

Intermountain Health Care, the largest health system in the state, owns three perinatal and one pediatric tertiary care centers. Department staff works with providers in these centers on a number of initiatives, including induction policies, appropriate delivery site for low birth weight infants, electronic medical records, Perinatal Task Force, etc.

Public health and health professional educational programs and universities
Two schools of public health offer a Master of Public Health degree and one offers a PhD in Public Health (University of Utah and Brigham Young University). MCH and CSHCN staff is involved with several colleges and Universities in providing internships for students in these programs and others, such as nursing, pharmacy, pediatric medicine, social work dental hygiene, and health education. Title V programs have employed several health profession students for different projects, such as Medical Home, and reproductive, adolescent and oral health. Department of Health staff has participated in teaching classes in many of these programs.
University faculty participates in various Title V activities. The University of Utah Departments of Family and Preventive Medicine and Obstetrics and Gynecology invited Division staff to collaborate on a perinatal Epidemiology workgroup for projects related to mothers and children. The Department of Obstetrics and Gynecology asked the MCH Epidemiologist to support data needs for a NIH-funded fetal death project. University Department of Family and Preventive Medicine, Department of Pediatrics and Department of Obstetrics and Gynecology representatives sit on the Perinatal Task Force, the PRAMS Advisory Committee and others. Staff from these departments, as well as the College of Nursing, participate in the perinatal mortality review committee. Members of these groups are regularly available for technical and clinical questions.
Department of Pediatric faculty serves on CSHCN advisory committees, including the Early Intervention Interagency Coordinating Council, the Medical Home Advisory Council, the Newborn Hearing Screening Advisory Committee and the Genetics Advisory Committee.

The Utah Department of Health collaborated with the Nevada State Health Department to develop the Great Basin Public Health Leadership Institute, (GBPHLI) which graduated its first class in March 2005. The second class of GBPHLI scholars started in May 2005 and includes Title V staff. The Department leadership capacity will be enhanced as more Department staff graduate from the Institute.

Title V staff has been actively involved with the Rocky Mountain Public Health Education Consortium which provides a number of educational offerings through on-site educational opportunities, such as the MCH Summer Institute, a MCH PH Certificate Program through the University of Arizona, and distance learning opportunities, such as online modular courses The Consortium is a collaboration of academic and state, local and tribal MCH leaders working to provide workforce development opportunities for public health professionals working in areas of with a dearth of educational programs.

Utah CSHCN is in its third year of the MCHB-funded Utah Leadership Education in Neurodevelopmental Disabilities (ULEND) program. CSHCN collaborates with Utah State University, Center for Persons with Disabilities and University of Utah, Department of Pediatrics, in an MCHB Leadership Grant. ULEND provides opportunities for students and professionals in health related disciplines (pediatrics, physical and occupational therapy, speech-language pathology, psychology, nutrition, social work, audiology, pediatric dentistry, genetics, nursing, business/marketing, special education, and families) to increase their knowledge and skills in providing services and supports to children with neurodevelopmental disabilities.

Other federal grant programs
The Division is the recipient of a number of federal grants from CDC, USDA, HRSA, etc., including WIC, Immunization Program, PRAMS, Preventive Block Grant, disease-specific prevention grants such as arthritis, cancer, and others such as Early Hearing Detection and Intervention (EHDI), The Utah Registry of Autism and Developmental Disabilities (URADD), The Utah Genetics Implementation Project (UGIP), HRSA Grant for Coordinated Dental Access System, to name a few.

WIC
The state WIC Program is located in the Bureau of Maternal and Child Health, which greatly enhances opportunities for coordination of efforts. During the previous five years, the MCH Bureau made significant management changes in the WIC Program that now foster a strong collaboration with other programs focused on the health needs of mothers and children. Other programs have enthusiastically welcomed the collaboration opportunities with WIC. WIC staff members participate on various committees related to maternal and child health, including the MCH/CSHCN Advisory Committee, Perinatal Task Force, MCH Epidemiology, immunizations, nutrition, and data integration efforts.

The Immunization Program and WIC have collaborated on an incentive program for WIC-enrolled children who are adequately immunized at age two. WIC staff provides nutritional expertise for other program efforts, such as in helping the PRAMS program develop a report on obesity in pregnancy. The challenge remains, however, to get local agencies to view WIC as a program that has opportunities to promote healthy mothers and children through collaboration and integration of services.

WIC committed to funding a half-time data analyst in the Data Resources Program to support review and analysis of WIC data. Program staff has much improved access to use of WIC data for program planning.

Family Planning Programs
The Title V agency has a strong relationship with the state Title X agency, Planned Parenthood Association of Utah (PPAU). The Chief Executive Officer of PPAU has participated for a number of years on various advisory committees and task forces to address the needs of women of reproductive age in the state. The Reproductive Health Program provides technical assistance and consultation to local health departments on family planning services.

Pregnant women and infants eligible for Title XIX and assist them in applying for services
The Division has MOAs with 25 agencies to provide screening for presumptive eligibility (PE) for prenatal Medicaid at 53 sites throughout the state, including local health departments, community health centers, a farm worker health program, a homeless clinic, Indian Health Service provider,

clinics, and hospitals. The Division provides telephone presumptive eligibility screening for Salt Lake County residents through Baby Your Baby by Phone.
The Baby Your Baby Hotline (BYB) refers callers needing financial assistance for prenatal care to a nearby PE site. WIC staff also refers women to PE as needed. Women are then referred to an eligibility office to apply for Medicaid.

The Division works with BYB on promotion of BYB as a resource for information on financial assistance for prenatal care and other maternal and child health related information.

Utah Clicks, a web-based online screening and application system, will enable families to easily apply for services, such as PE, Medicaid and others, thus reducing time in clinics or eligibility offices. The system will be rolled out fall 2005.

F. HEALTH SYSTEMS CAPACITY INDICATORS

Health Systems Capacity Indicators

In reviewing the Health Systems Capacity Indicators (HSCI), Utah data indicate that we have made progress in several HSCIs since last year, including Medical children under age one receiving an initial periodic screen, percent of pregnant women receiving adequate prenatal care, and Medicaid enrolled children who received dental service. Two areas that did not improve and in fact regressed were the hospitalization for asthma and the children on SSI receiving rehabilitative services from the CSHCN Program.

HSCI -- 1: The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -- 493.9) per 10,000 children less than five years of age.
The rate of hospitalization increased from 17.4 in 2001 to 18.6 in 2003 and 2004 (2004 data are provisional) which may reflect the increase in overall asthma diagnoses in children under 18 years in Utah. This increase is concerning and will be further examined to identify factors associated with the increase. The Asthma Program, housed in the Division of Community and Family Health Services, is working to determine the reason for the increase in hospitalizations. The program recently produced a report on asthma in Utah. Data regarding asthma prevalence among preschool and elementary aged children is needed. Asthma hospitalizations are highest for children under five. The Asthma Program Plan includes working with the health care system to identify barriers to care for those with asthma and to ensure that children in schools have access to inhalers as needed. The 2004 Legislature passed a bill that allowed children to carry inhalers to school to use as needed for their asthma. This legislation was necessary due to the "zero tolerance" to drugs policy of the Utah schools. The Program has also worked to reduce the number of children exposed to tobacco smoke in their homes. The Program developed a manual for schools that provides them with comprehensive information about asthma in children that is a thorough resource for school personnel. The manual can be accessed at http://health.utah.gov/asthma/schools.html

HSCI -- 2: The percent of Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.
This HSCI increased from the previous three years from 81.4% to 82.7%. While a 1.3% increase is small, it does indicate that efforts to improve access to care for infants on Medicaid have had some impact. Obviously with more than 16% of Medicaid enrolled infants not receiving an initial screen, we have more work to do to ensure that all Medicaid enrolled infants access health care. The Medicaid agency contracts with local health departments for CHEC (Utah EPSDT) outreach to assist families in accessing health care services. Efforts targeting infants after birth need to be enhanced if we are to see better access for infants. The local health departments also provide targeted case management services for Medicaid families which need to include education about the importance of the well child visits, especially for children under age one year. Title V needs to work more closely with Medicaid to develop better strategies to improve on this indicator.

HSCI -- 3: The percent of State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.
This Health System Capacity Indicator showed remarkable improvement since last year. The previously reported indicator was 58.2% of infants receiving a periodic screen. The percent of infants receiving a periodic screen for 2003 was 89.2%. The dramatic increase may be due to better reporting of information. Regardless of the reason for the increase, we are very pleased to see the improvement.

HSCI -- 4: The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80% on the Kotelchuck Index.
The increase in pregnant women receiving adequate care is encouraging because it reflects an improvement after several years of decline in this indicator. The Utah Department of Health instituted a number of different strategies to increase awareness among women of childbearing ages about the importance of early and ongoing prenatal care. The Department launched a new Baby Your Baby campaign to promote the importance of early and ongoing prenatal care called 13 by 13 -- get into prenatal care by the 13th week and get thirteen visits. The media spots were created in partnership with a local TV station, a CBS affiliate. The spots were aired on the TV station and also on several radio stations. The Department is currently completing an evaluation of the campaign to determine its effectiveness.

The Department is working with the University of Utah Department of Obstetrics and Gynecology to develop a mechanism to determine provider practices relative to early prenatal care. We have received a number of anecdotal reports from health care providers that many prenatal care providers delay the start of prenatal care until early second trimester. Providers in a survey that the Department conducted several years ago indicated that the majority supported ACOG's standard of starting prenatal care in the first trimester or as soon as pregnancy is confirmed. We will continue these efforts and monitor the data to ensure that this increase is the beginning of an ongoing turn-around in this indicator. We plan to work with our partners to identify additional barriers to early prenatal care so that we can address those along with the efforts we have already put into place.

HSCI -- 5: Comparison of health system capacity for Medicaid, non-Medicaid and all MCH populations in the state.
The four indicators show that the Medicaid participants do not fare well compared to the non-Medicaid population. Data indicated that 8.2% of infants born to Medicaid mothers were low birth weight compared to 6% of non-Medicaid mothers. Infant deaths were also higher among Medicaid mothers at 6.7 per 1,000 live births compared to 3.9 per 1,000 live births to non-Medicaid mothers. Only 67.1% of Medicaid mothers entered prenatal care in the first trimester compared to 83.6% of non-Medicaid mothers. Adequacy of prenatal care also is much lower for Medicaid mothers at 67.9% compared to 81% of non-Medicaid mothers. These findings are concerning, especially the low birth weight and infant mortality indicators. The Department has always struggled with the definition of a "Medicaid mother" since there are several categories of Medicaid benefits that may result in different outcomes. For example, a mother who is on Prenatal Medicaid at 133% of the Federal Poverty Level may be very different from a mother who qualifies for Medicaid's Emergency Medical Services, who are often without documentation of residency in the United States. As a result, including all women who are on Medicaid, regardless of program type or time on the program may skew the data. The Department has not been able to determine a mechanism at this point to separate out the women who are on Prenatal Medicaid versus those who are on other Medicaid benefit programs at lower income levels who may have poorer outcomes because they may be more disadvantaged. We will continue to explore these data to determine a better way of analyzing the data to get a more accurate picture of the "Medicaid mother" than previously. However, we are concerned about these findings, as is Medicaid, and both agencies will work to gather more information on these disparate outcomes.

HSCI -- 6: Medicaid eligibility levels: The percent of poverty level for eligibility in the state's Medicaid programs for infants (0-1), children, Medicaid and pregnant women. Medicaid eligibility is at 133% of the Federal Poverty Level (FPL) for infants and children under 6 years of age and for pregnant

women. The income eligibility for children 6 through 18 years is 100% FPL. These eligibility levels have remained the same for many years, which may be a barrier to those from working poor families who have no insurance or means to purchase insurance. Efforts to eliminate the asset test for children and pregnant women have been unsuccessful although advocates will continue to lobby for the asset test to be dropped since it restricts many families from eligibility because they have two cars or a savings account of more than $3500, as examples of assets that are counted against families.

HSCI -- 6: SCHIP eligibility levels: The percent of poverty level for eligibility in the state's SCHIP programs for infants (0-1), children, SCHIP and pregnant women.
The income eligibility for Utah's CHIP program is 200% FPL for infants and children to age 18. Utah CHIP does not cover pregnant women. Utah's CHIP Program provides two levels of benefits depending on the family income level. Co-payments for some services are required for both levels of coverage. CHIP's enrollment has been capped until July 1, 2005 when it will be opened due to increased funding allocation form the 2005 Legislature. The increased funding will allow the program to cover approximately 40,000 children, an increase of 12,000 from previous years. The legislation proposed in the 2005 Legislative Session to drop the asset test for children would have enabled CHIP to move some children to Medicaid, thus freeing up "slots" for other children who would be eligible for CHIP but weren't able to get in due to the capped enrollment. Now that the program has additional funding, the Department hopes that eligible children will readily be able to obtain CHIP coverage.

HSCI -- 7: The percent of EPSDT eligible children aged 6 though 9 years who have received any dental service during the year.
This indicator has increased since 2002 from 41.9% to 47.2% in 2004. The improvement in the indicator is encouraging; however, more than 50% of children still are not getting dental services during the year.

The Utah Department of Health has initiated numerous efforts to improve health systems capacity to address access to care which is reflected in the indicators that changed in the direction of reflecting systems capacity building. The improvement in receipt of prenatal care, dental services, and EPSDT screening is reassuring; however, the state will continue its efforts in these areas to promote ongoing improvement. More than 15% of the Medicaid enrolled infants are not being seen for an initial EPSDT screen. The Title V agency will continue to work with Medicaid and local health departments to improve the percentage of children being seen in the first year.

We are very pleased to see the increase in dental care access among Medicaid children. However, more than 50% of Medicaid enrolled children did not get dental care in the previous year. The Oral Health Program has initiated a number of interventions to increase access for children, including working with Medicaid and external partners to develop strategies to increase children's access to dental services. For example, they have allocated small grant awards (from a HRSA grant) to each of the local health departments to promote oral health awareness. Two local health departments have used the funding to help support the effort to establish a dental clinic for those in need. The Oral Health Program has worked with a grant-funded project called HAP -- Health Access Project, to expand its efforts to dental care access. HAP was designed to address the needs of the uninsured in Salt Lake County by engaging physicians and hospitals to volunteer time and services for uninsured individuals who have no means of obtaining health care services. The Salt Lake Valley Health Department is working with United Way on a project to place sealants on 3rd graders' teeth in Title I schools. Initial efforts revealed that waiting until children are in third grade was too late as many children already had significant dental caries. The project is now focusing on first grade children in an effort to reach the children before they have significant caries, to get them into dental care, and to educate them on prevention of caries. Through a HRSA funded grant, the Oral Health Program is developing a media campaign on the importance of dental care for pregnant women and young children. In addition, the Oral Health Program has submitted an application to the national Purchasing Institute which is focused on state teams, including the Title V Director and the Medicaid Deputy Director, along with the State Dental Director to work on access to dental care for children and adults in Utah. Hopefully the Institute, if Utah is accepted will result in a better understanding of the unique dental practice system, so different from the physician practice system.

HSCI -- 8: The percent of state SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Programs. The percent declined slightly from 34.6% in 2003 to 34.0% in 2004. The decrease in children on SSI who received rehabilitative services from the State CSHCN programs may reflect services being provided outside the CSHCN programs, or it may be a factor of decreased reporting of SSI coverage, either by the parent or by the CSHCN clinicians. Changes have been made to the data collection program to make SSI status a required field, and training to improve reporting accuracy has been undertaken.

HSCI -- 9A (General MCH Data Capacity): The ability of the state to assure MCH program access to policy and program relevant information.
Utah has strong data access and linkage ability. We are able to link infant birth and death certificates, birth and Medicaid files, and we also have in place a hospital discharge database, a birth defects surveillance system, and PRAMS. The two areas that need further development are the linkage of birth and WIC data (some of the limitation here is linkage process itself, not access) and the linkage of birth records with the newborn screening data base. With the data linkage capacity, the Title V agency has been increasingly able to analyze data that are needed for program planning, as well as supporting external partners in their work, such as the University of Utah Department of Obstetrics and Gynecology NIH Fetal Death Study. Data capacity has grown exponentially in the Title V agency and the Department of Health in general. Having access to data and the ability to link data strengthens programs' abilities to determine factors associated with various outcomes to then develop more effective strategies to address the associated factors.

HSCI -- 9B (Data capacity -- adolescent tobacco use): The percent of adolescents in grades 9 through 12 who reported using tobacco products in the past month.
The Department of Health, in collaboration with the State Office of Education, conducts the YRBS in schools each year. The YRBS is not conducted with CDC support due to a legislative mandate that the state could not apply for CDC funding for school activities related to HIV prevention. This mandate resulted from legislators who erroneously thought that CDC required condom promotion, which is counter to the state's abstinence-based policy. The State Office of Education was unwilling to pursue continuing funding for the YRBS as a result. The Utah Department of Health has picked up that function with funding from other sources and conducts the survey annually with the cooperation of the State Office of Education. YRBS is conducted in conjunction with another survey, Youth Tobacco Survey. Fortunately Utah's YRBS methodology has allowed the Utah data to be weighted by CDC, thus accomplishing an YRBS process that is in compliance with CDC policy. Fortunately, the Department of Health has a very strong Tobacco Prevention and Control Program that engages community partners effectively. We also are very fortunate to have a low tobacco use rate for all ages compared to the national data. Utah's predominant religion (LDS) does not allow for tobacco use among its members, a majority of the Utah population.

HSCI -- 9C: The ability of the state to determine the percentage of children who are overweight or obese.
The state participates in the YRBS, PedNSS, and WIC with the Title V programs having access to these important sources of information. These data sources become even more important as the state is prioritizing this indicator as one of its top priorities for FY2005-2010. We also will be using BRFSS data for determining the prevalence of adult women with overweight and obesity.

IV. PRIORITIES, PERFORMANCE AND PROGRAM ACTIVITIES

A. BACKGROUND AND OVERVIEW

The initial planning process for the FY2005-2010 needs assessment process included a review of the FY2000 process to determine its effectiveness in identifying needs for mothers and children in the state from a broad perspective. The review led us to realize that we needed to seek broader input on the needs of pregnant women, mothers, young children, adolescents and children and youth with special health care needs than we had obtained for the previous needs assessment. In our discussions, we decided to ensure that we had input from individuals representing a broader view of health needs and issues for mothers and children in the state, such as parents, including parents of children and youth with special needs, members from all advisory committees that relate to MCH or CYSHCN issues, as well as other stakeholders working with mothers and children in the state.

The lead staff in the Division of Community and Family Health Services developed a plan for the five-year needs assessment that included development of a survey for each of the MCH populations and health service or system issues, involvement of the MCH/CSHCN Advisory Committee and its separate subcommittees, review of the recommended priority areas identified by each of the subcommittees to determine the final priorities for the Title V efforts for FY2006-2010. Key staff in the Division also participated in an abbreviated CAST-5 process to identify areas in which the agency needs to develop additional capacity.

Division staff developed a key informant survey to solicit opinions on key health issues in four areas: mothers and infants; young children and adolescents; children and youth with special health care needs; and, health care services. Various staff and outside partners were included in the development of the survey to ensure that it reflected key issues for each of the MCH populations. Members of the State ICC were involved in the key informant survey to ensure that they had an opportunity to voice their concerns regarding children and youth with special needs. The survey was designed for online response, however, hard copies of the survey were sent to individuals for whom we had no email address. With the request for survey participation, we encouraged those we contacted to forward the survey information to anyone they thought might be interested in providing input so that we could obtain as many responses as possible. Numerous individuals in the state representing various components of the system, such as local health departments, community health centers, private providers, advocacy organizations, the Department's Ethnic Healthy Advisory Committee (which includes representation of the various ethnic and minority populations in the state), parents of children and youth with special health care needs, agencies working with mothers and children, various advisory committees that address issues relating to the three MCH populations, etc. were contacted to participate in the survey.

Division data staff tabulated the survey responses and sorted the issues by rank order in each of the categories mothers and infants; children and youth; children and youth with special needs, and health care service. Almost 700 individuals (694) were contacted directly to participate in the survey, with 411 responses returned for a response rate of 59% (based on the number directly contacted). The respondents may include others we did not directly contact since we had encouraged wide distribution of the survey. Of the responses received, 83% were online responses. Interestingly, the largest group of responders was parents comprising 22% of the responders, with local health department staff comprising the next largest group at 17%.

The results of the survey were as follows:
Health Issues for Mothers and Newborn Babies
Unplanned pregnancies
Obesity
Depression or Other Mental Health Problems
Closely Spaced Pregnancies
Poor Nutrition During Pregnancy

Health Issues for Children and Adolescents

Lack of Physical Activity
Obesity
After School Supervision
Teen Pregnancy
Depression or Other Mental Health Problems

Health Issues for Children and Youth with Special Health Care Needs
Lack of Physical Activity
Lack of Respite Care
Depression or Other Mental Health Problems
Transition to Adult Life and Self-Sufficiency
Lack of Child Care

Health Care Services Issues
Dental Insurance
Obtaining Financial Help for Health Care
Health Insurance
Services not Covered by Insurance
Dental Care

The top five issues for each category came as no surprise to the Title V staff, although the high ranking of lack of physical activity in the CSHCN area did result in some discussion, especially given that it was ranked higher than respite care.

B. STATE PRIORITIES

The needs assessment process included a review of status on National and State Performance and Outcome Measures, as well as Health Status, Health Systems Indicators and health care systems in the state. This review assisted in identifying priority areas along with the top issues obtained from the key informant survey. The needs assessment process also included a review of status on National and State Performance and Outcome Measures, as well as Health Status, Health Systems Indicators and health care systems in the state. This review assisted in identifying priority areas along with the top issues obtained from the key informant survey. The state accomplished 11 National Performance Measures. The Measures that we did not accomplish included several that we had made progress on, but the indicator was slightly lower than the objective. The areas that we did not achieve included: up-to-date immunizations for children, deaths of children due to motor vehicle accidents and youth suicides, uninsured children, low birth weight, very low birth weight infants born in tertiary centers, and entry into prenatal care. The measures for immunizations and uninsured children are 2004 data, however, the vital records data are provisional, which may impact the number of National Performance Measures obtained. State Performance Measures were all noted as accomplished, however, as with the National Performance Measures, some are reported with provisional data, so this too may change what was accomplished or not.

For quantitative methods, staff reviewed demographic data, health system capacity data to identify gaps and health issues that were becoming increasingly concerning, such as asthma hospitalizations for young children; the disparity among Medicaid mothers related to entry into care, adequacy of care, low birth weight and infant deaths compared to non-Medicaid mothers; and, the low percent of Medicaid enrolled children who received dental services. Data capacity is strong in the Utah Department of health and has progressed to almost full capacity over the last several years.

Key Title V staff participated in an abbreviated version of CAST-5 to evaluate the state Title V agency's capacity. The Title V Director, MCH and CSHCN Bureau Directors along with other key staff reviewed the elements of CAST-5 to assess the Utah Title V agency's capacity needs. Overall the review indicates that Utah's Title V agency has much capacity and the elements that were noted as needing improvement really only reflect the desire to development these elements to a higher level. The elements are in place, but barriers may prevent staff from accomplishing as much as they would

like. Overall, the agency has capacity for 21 of the 28 elements, with the remaining 7 elements needing improvement or further development. The seven elements included:
• Authority and funding sufficient for functioning at the desired level of performance -- the challenges in this element include: inability to create new positions to address capacity needs due to legislative restrictions; restrictions on applying for grant funds if new positions are needed to carryout the grant; and limited state funds for grants that require non-federal match.
• Mechanisms for accountability and quality improvement -- we have informal processes in place for quality improvement for many programs, but limited ability to implement quality improvement with contractors, such as local health departments. Programs providing direct services tend not to be receptive to quality improvement as it interferes with service provision.
• Formal protocols and guidance for all aspects of assessment, planning and evaluation cycle -- this element is one that we need to focus more on and develop staff capacity.
• Adequate data infrastructure -- We have strong data support, but capacity needs to be built to better support data needs of the state Title V agency in its work, especially rlative to ethnic and minority population data
• Other relevant state agencies -- While the UDOH has strong collaborative relationships with many state agencies, the State Office of Education has been very difficult to engage in collaborative initiatives. With a new Executive Director, perhaps this will change for the better.
• Businesses -- this is an area that the Division of Community and Family Health has embarked on to a certain degree, but needs further development.
• Ability to influence policy-making process -- The Department has the ability to influence policymakers to the degree that is within the boundaries of state government roles and the Governor's agenda. The new Executive Director of the Department of Health has vast experience in government nationally which will greatly benefit public health and Title V in the state as he works to overcome challenges we face.

Division staff developed a key informant survey to solicit opinions on key health issues in four areas: mothers and infants; young children and adolescents; children and youth with special health care needs; and, health care services. Various staff and outside partners were included in the development of the survey to ensure that it reflected key issues for each of the MCH populations. Members of the State ICC were involved in the development of the survey to ensure that they had an opportunity to voice their concerns regarding children and youth with special needs. The survey was designed for online response, however, hard copies of the survey were sent to individuals for whom we had no email address. With the request for survey participation, we encouraged those we contacted to forward the survey information to anyone they thought might be interested in providing input so that we could obtain as many responses as possible. Numerous individuals in the state representing various components of the system, such as local health departments, community health centers, Department's Ethnic Health Advisory Committee (which includes representatives of each ethnic and minority population in the state), private providers, advocacy organizations, parents of children and youth with special health care needs, agencies working with mothers and children, various DOH advisory committees that address issues relating to the three MCH populations, etc. were contacted to participate in the survey.

In addition to the priorities that emerged from the needs assessment process, the MCH Bureau sponsored State Perinatal Taskforce meetings to identify four priorities to work on over the next year or so. Of all the issues included in the selection list, four priority areas emerged:
Family planning
Low birth weight and prematurity
Barriers to prenatal care
Depression and other mental health issues
These four priorities correspond to the issues identified through the key informant survey. Members of the Taskforce have signed up for one of the four subcommittees to address each of the priorities. The subcommittees are developing strategies to address each of the priority areas.

The Title V leadership reviewed the survey results, the recommendations of the subcommittees to develop the state priorities. After some thoughtful discussion, the following were identified as the

State Priorities for FY2005-2010 including the populations impacted:
1. Depression and mental health (mothers, children)
2. Obesity (mothers [pre-pregnant and weight gain in pregnancy], children)
3. Intendedness of pregnancy (includes short interpregnancy spacing)
4. Medical home (all)
5. Access to health care for women of childbearing ages and children (all)
a. Women of childbearing ages who do not have insurance
b. Rural health (all, especially CSHCN)
6. Oral health (all)
7. Transition and vocational rehabilitation (CSHCN)
8. Ethnic/cultural issues (all)
9. Genomics (all)

The Division will continue to explore information related to the nine priorities, especially the two issues for which we did not develop a state performance measure, ethnic and cultural issues and genomics. We chose not to develop state performance measures on these two priorities since they were added to the list after some discussion of the areas in which we need to work on, but were not yet ready to develop a state performance measure. The ethnic and cultural area is one that all programs in the Division need to address, but we found it difficult to identify a measure to achieve. We will continue to explore this area with the Department's Center for Multicultural Health. We want to develop strategies to address how we as the state Title V agency function relative to ethnic and cultural diversity. Genomics is such a new field that we have yet to determine how to incorporate this developing area into our work. The Department has a Genomics Program that is new and just beginning to explore how it can assist other programs in their work. The Program is designed to highlight how genomics can impact public health practice. In June 2005, program staff met with staff from other programs to discuss strategies and directions for the future. The website is http://health.utah.gov/genomics/

The other seven priorities were expanded into nine state performance measures which are:

1. The percent of women of reproductive ages (18-44 years) who are uninsured

2. The proportion of pregnancies that result in a live birth that are intended

3. The proportion of women who have a live birth reporting moderate to severe depression who seek help from a doctor or other health care worker

4. The percent of women with normal prepregnancy weight who deliver a live born infant

5. The percent of women who deliver a live born infant with appropriate pregnancy weight gain

6. The percent of children who are at-risk for overweight and overweight

7. The percent of youth who report feeling so sad or hopeless almost every day for two weeks or more that they stopped doing usual activities during the prior 12 months

8. The percent of children 6 - 9 years of age enrolled in Medicaid receiving a dental visit in the past year

9. The percent of CSHCN children in rural areas receiving direct clinical services through the state CSHCN programs

We reserved the tenth state performance measure for either genomics or ethnic and cultural issues, or for another issue that may arise in the next year or two.

This year's needs assessment effort has produced invaluable information about the needs of Utah mothers, infants, children, adolescents and children with special health care needs, including

adolescents with special health care needs, that the Division and others will be able to utilize in planning improved services and programs to better address the populations served through these funds. Recognizing that the needs assessment is an ongoing process, Title V leadership will continue to monitor Utah's progress in the priority areas identified in the needs assessment process, including those that were not included in the final list. Each year as additional data become available, such as adequacy of prenatal care statistics, programs review the data and seek strategies to address the findings. We will continue to review data as it is available to assess needs of mother, infants, young children, school-aged children and youth, including those with special health care needs as we implement the plans for the coming five years.

Plans to address the new State Performance Measures include:

Uninsured women - The Division will promote awareness of the prevalence of uninsured women and identify strategies to improve the rate. The Division will continue collaboration with Medicaid on an 1115 Research and Demonstration Waiver to expand coverage for women who lose eligibility 60 days following a pregnancy. The Division will engage in discussions with Medicaid, CHIP, PCN to discuss possible strategies to address the higher rate of uninsured women compared to the general population.

Intended pregnancy - To address intendedness of pregnancy, we will analyze 2004 PRAMS data and WIC data on pregnancy intention. The RHP will educate women about fertility cycles, correct contraception use, and healthy interpregnancy spacing through educational messages.
Perinatal depression - During 1999-2001, 25.2% of PRAMS respondents indicated moderate to severe postpartum depression. We will raise awareness of perinatal depression and its effects on infant development and on the family by developing educational messages for the public. We will also work to increase provider awareness of the prevalence among Utah mothers.

Normal prepregnancy weight - The Reproductive Health Program (RHP) will disseminate a report on adverse pregnancy outcomes associated with prepregnancy overweight or obesity to health care providers, along with BMI calculators to encourage them to counsel women about healthy weight.

Appropriate pregnancy weight gain - The Division will increase awareness of risks associated with inadequate and excessive weight gain during pregnancy by promoting appropriate weight gain to the public, provider counseling to pregnant women, and nutrition education counseling.

Overweight and at risk of overweight children - The Division will implement a coordinated effort to measure the prevalence of at risk of overweight and overweight children, promote healthy nutrition and physical activity. Eight programs will coordinate efforts to address this problem in Utah children. The Gold Medal School initiative will be expanded to additional schools.

Children's mental health -- The Division will hire a Children's Mental Health Promotion Specialist to assess the Title V agency's capacity to address mental health issues and explore options to promote primary prevention and screening for children and women of childbearing ages. Responsibilities will include involvement in the Youth Suicide Prevention Task Force.

Children's oral health - The Oral Health Program (OHP) will implement a public awareness campaign on the benefits of early and regular dental visits. The program will work with Medicaid staff to expand outreach efforts.

Rural services for CSHCN - The Bureau of CSHCN will continue its contracts with five local health departments for itinerant clinics in nine rural sites. CSHCN will provide ongoing consultation and support for care coordination issues. CSHCN will work to integrate local rural clinic activities into the statewide Medical Home effort. The CSHCN Bureau will continue to improve services to rural CSHCN through telehealth technology.

C. NATIONAL PERFORMANCE MEASURES

Performance Measure 01: *The percent of newborns who are screened and confirmed with condition(s) mandated by their State-sponsored newborn screening programs (e.g. phenylketonuria and hemoglobinopathies) who receive appropriate follow up as defined by their State.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	98.5	98.5	98.5	98.5	98.5
Annual Indicator	99.1	98.1	98.6	100.0	100.0
Numerator	48000	48125	49633	51	51
Denominator	48454	49041	50314	51	51
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	99	99	99	99	99

Notes - 2003
Data are from occurrent births Office of Vital Records and Statistics. UDOH 2003 and Newborn Screening Program CY 2003 data.

Data for 2003 and 2004 are now reporting on the revised Performance Measure.

Notes - 2004
Data are from occurrent births Office of Vital Records and Statistics. UDOH 2003 and Newborn Screening Program CY 2003 data.

Data for 2003 and 2004 are now reporting on the revised Performance Measure.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 98.5% and the Annual Indicator was 99%.

The Newborn Screening Program continued its surveillance and identification of infants with congenital hypothyroidism, galactosemia, hemoglobinopathy, and phenylketonuria (PKU). Infants were identified from all over the state. Their medical home provider was contacted and coordination of follow up and referral to specialty consultants was provided.

The pilot study for Expanded Screening using Tandem Mass Spectrometry was begun in October of 2003. This is an effort among the University of Utah Medical Genetics Department, Associated Regional and University Pathologists, Inc., a private laboratory, and the Department of Health. Preparation for the study included education of medical personal, development of brochures, establishment of computer network for exchange of electronic data, establishment

of follow up procedures, mailer design, and development of collection kit. Participation in the study began at the University of Utah Health Sciences Center's nursery. The number of participants increased significantly in January when the Spanish version of the consent form and brochure became available.

Kits were sold to all institutions of birth and lay midwives who do home deliveries. Consultations with all providers were made available by phone or site visit. Consultations and education of families and the general public continued. The program has worked closely with Vital Records and Hearing Screening to provide birth record numbers (BRN) for those missing in their records. All babies who are marked transferred on the birth certificate are sent to the program to verify the BRN, and the results are returned to Vital Records, as well as the Hearing Screening program. The BRN is verified on newborns that have a 'not normal' hearing result.

CSHCN continued to provide collaborative and financial support to the University of Utah Health Sciences Center Metabolic Follow-up Clinic. CSHCN staff worked with families, insurance companies, and Medicaid to facilitate billing and coding for these services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute Newborn Screening kits to birthing facilities			X	
2. Provide training and consultation to hospitals and pediatric health care providers about newborn screening				X
3. Work with affected children's medical homes to identify, follow and refer newborns with identified metabolic, hematologic or endocrine disorders				X
4. Implement specific criteria for adding, modifying, or deleting a screening test to Utah's battery of newborn screening tests				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Newborn Screening Program will continue its surveillance and identification of children with congenital hypothyroidism, galactosemia, hemoglobinopathy, and phenylketonuria (PKU). The care coordination and data tracking system will be continued with additions, subtractions, and fine-tuning implemented as necessary. Disorders that are not currently included in the Utah battery of screening disorders and testing methods for newborn screening will be reviewed, and on-going discussions of applicability will continue.

The program will participate in a two-year pilot study to evaluate expanded screening using Tandem Mass Spectrometry. This pilot will be a collaborative effort between The Associated Regional and University Pathologists, Inc. (ARUP), the University of Utah Department of Pediatrics, Division of Genetics, and the Utah Department of Health.

Newborn Screening kits will be sold to all institutions of birth and lay midwives who perform

home deliveries. Consultations with all providers will be available by phone or site visit. Consultations and education of families and the general public will continue.

The Newborn Screening Program will continue to collaborate on data integration and streamlining of data collection. The program will continue its involvement in the Birth Record Number linking of newborn databases. It will support and facilitate the "Medical Home" model of health care.

CSHCN will continue to provide collaborative and financial support to the University of Utah Health Sciences Metabolic Follow up Clinic, which follows children with PKU and galactosemia. CSHCN staff will continue working with families, the state Insurance Department, Medicaid, and private insurance companies to facilitate the billing and coding systems.

c. Plan for the Coming Year

The Newborn Screening Program will continue its surveillance and identification of children with congenital hypothyroidism, galactosemia, hemoglobinopathy, and phenylketonuria (PKU). The care coordination and data tracking system will be continued with additions, subtractions, and fine-tuning implemented as necessary. Disorders, not currently in the Utah battery of screening disorders, and testing methods for newborn screening will be reviewed, and on-going discussions of applicability will continue.

The program will expand its battery of tests from 4 disorders to 36 disorders in January 2006. The disorders to be added are biotinidase, congenital adrenal hyperplasia, and MCADD, along with the other disorders identified through MSMS technology. The state rule guiding the newborn screening process will be rewritten and approved by mid summer 2005. New equipment will be bought, training of lab staff will be completed, and verification of the tests completed prior to the implementation date. New follow up protocols will be established in conjunction with the program's consultants. Education materials will be developed and distributed in written form (handouts, newsletters, etc.) as well as redesign of the state's website. A unique public-private partnership will be undertaken to provide the MSMS technology and testing.

The program will continue to participate in a two-year pilot study to evaluate expanded screening using Tandem Mass Spectrometry. This pilot will be a collaborative effort between The Associated Regional and University Pathologists, Inc. (ARUP), the University of Utah Pediatric Genetic Department, and the Utah Department of Health. The pilot ends October 2005.

Newborn Screening kits will be sold to all institutions of birth and lay midwives who do home deliveries. Consultations with all providers will be available by phone or by site visit. Consultations and education of families and the general public will continue.

The Newborn Screening Program will continue to collaborate on data integration and streamlining of data collection. The program will continue its involvement in the Birth Record Number linking of newborn databases. It will support and facilitate the ‘Medical Home' model of health care. Integration with the CHARM project is underway, with Newborn Screening to be the next program added in July 2005.

CSHCN will continue to provide collaborative and financial support to the Metabolic Follow up Clinic, which follows children with PKU and galactosemia. CSHCN stall will continue working with families, the state Insurance Department, Medicaid, and private insurance companies to facilitate the billing and coding systems.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				63.7	63.7
Annual Indicator			63.7	63.7	63.7
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	63.7	65	65	65	65

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are the data from the 2001 CSHCN SLAITS for this performance measure.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 63.7% and the Annual Indicator was 63.7%.

CSHCN employed a part-time family advocate who is also the State Coordinator for Family Voices. In her role as a CSHCN family advocate, she has worked directly with parents providing them with resources and advocacy information and providing parent-to-parent support. As the State Family Voices Coordinator, she continued to provide a parent perspective and advocate for special needs children and families through representation on numerous boards and committees. Additionally, the family advocate worked closely with The Utah Medical Home Collaborative Project staff providing support and direction to family advocates in each of the eight medical home practice sites. The family advocate traveled to the individual practice sites with the Medical Home team to provide support and information to the family advocates in their communities. Montezuma Creek was one of the medical home sites where the family advocate visited the clinic, which supports many Navajo families and children, many living long distances from the clinic with no access to electricity and phones. Another clinic the family advocate provided support to was a clinic with a large population of Latino Spanish-speaking families. The support resulted in involving many families in focus groups and individual contacts to obtain input on priorities and needs important to their families.

The Family Voices family advocate served as a core family faculty member of the Utah Leadership Education in Neurodevelopment Disabilities (ULEND). Through this effort she participated on the overall management of the project. Other activities included helping to develop the curriculum, presenting at didactic sessions and arranging for trainees to visit with families and their children and youth with special needs in their homes as well as arranging for families to speak about family issues in the didactic sessions.

The CSHCN Bureau continued to hold family advocacy and support as a priority area for CSHCN, especially for rural clinics. The contract with LINCS (Liaisons for Individuals Needing Coordinated Services) continued during FY2004. LINCS identified, trained and employed local parents who provided advocacy and resource information for families and children attending rural CSHCN clinics in their communities. Utah continued to collaborate with Measuring and Monitoring Community-Based System of Care Project staff at the Early Intervention and Research Institute at Utah State University to support efforts in measurement as well as use of data to drive system priorities.

CSHCN contributed to the Utah Family Voices grant proposals for a Utah Family to Family Health Information Center and a Technical Assistance grant to look at Health Insurance and Funding. Both of these proposals were successful and CSHCN has committed in-kind and financial support to enhance the work of family involvement at all levels.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue parent representation on MCH Advisory Committee and on other grant and CSHCN program advisory committees				X
2. Conduct family/consumer satisfaction surveys			X	
3. Contract with Liaisons for Individuals Needing Coordinated Services (LINCS) to provide parent representation at CSHCN rural clinics to identify, train and employ local parent advocates to provide support and resource information for families		X		
4. Work with Medicaid and other potential funding sources to identify opportunities for supporting parent involvement in CSHCN and Medical Home activities		X		
5. Provide consultation and education from of a Parent Advocate Coordinator to parent advocates who will in turn provide support and resource information for families and children			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Family advocacy and support continues as a priority area for CSHCN. The contract with LINCS (Liaisons for Individual Needing Coordinated Services) will be continued in FY2005. LINCS is identifying, training, and employing local parents who will provide advocacy and resource information for families and children attending rural CSHCN clinics in their communities. Family

satisfaction will be measured by completion of family satisfaction surveys by parents who have participated in CSHCN programs, including clinical programs, screening programs and Baby Watch / Early Intervention.

CSHCN continues to employ a part-time family advocate to work directly with parents providing them with resource and advocacy information. The family advocate is recruiting and training other parents to serve as mentors for families through the Medical Home and ULEND projects. Family representation on numerous boards and committees will continue. A parent's perspective and input will be obtained when writing new grants, other materials or implementing projects.

c. Plan for the Coming Year

Utah will include family input in all areas of Bureau administration, including involvement in the Needs Assessment and Block Grant planning to help build integrated systems of care for children and youth with special health care needs and their families. Family advocacy, support and involvement will continue as a priority. CSHCN will continue to employ a family advocate who is also the Utah Family Voices director. Family satisfaction for all nine Bureau programs will be measured by completion of family satisfaction surveys. CSHCN will renew the contract with LINCS (Liaisons for Individual Needing Coordinated Services), through which parents will be trained and will provide advocacy and resource information for families attending rural CSHCN clinics. An MCH technical assistance grant will support the development of training for accessing health care funding resources. The Family Advocate, in collaboration with CSHCN staff, will contribute to the annual Family Links conference, an annual collaborative information conference sponsored by family and disability organizations and state agencies.

This year will mark the beginning of the CMMS Family-to-Family grant for Family Voices. Through federal grant and in-kind funding from the Bureau of CSHCN, Family Voices will collaborate with the Bureau and other family organizations to respond to the changing needs of families through the development of the Family-to-Family Health Information and Education Center in Utah. The Center will support families in accessing health and health-related information through a family-run organization. Parent advocates will be trained and will support the Family Voices director in family advocacy activities. Additional volunteer parents will be trained in family support and will receive honoraria when they provide resource and advocacy information or consultation.

Parents will serve as mentors for families through the Medical Home and ULEND projects. Family representation on numerous boards and committees will continue. A parent's perspective and input will be obtained when writing new grants, other materials or implementing projects as well as making family involvement an objective in each new grant or funding source. The family advocate will expand the database of families of children and youth with special health care needs, which includes their documented issues and stories to enhance existing data.

The Utah Family Voices Director will collaborate with the University of Utah School of Medicine to mentor pediatric residents on family-centered care and the concept of medical home from a family perspective. She will also continue partner with the Utah Collaborative Medical Home project to develop information for families on the website and to support existing and new family advocates in the community with information, resources and training. She will also provide information and support to community medical home physicians to establish family advocates in their practices.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who*

receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				55.9	55.9
Annual Indicator			55.9	55.9	55.9
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	55.9	60	60	60	60

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are the data from the 2001 CSHCN SLAITS for this performance measure.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 55.9% and the Annual Indicator was 55.9%.

The Utah Collaborative Medical Home Project grant, funded through a federal MCHB Medical Home Development Grant, continued to develop and implement a statewide system to support medical homes for CYSHCN in primary care settings. Three additional practices were added to the original five medical home sites through participation in the National Initiative for Children's Health Quality (NICHQ) Medical Home Learning Collaborative. The new sites and Title V team collected data relevant to the medical home process, participated in monthly phone calls with NICHQ and sponsored a practice retreat in August 2003. All eight practices participated in monthly phone conferences and the administrative team made practice site visits every 1-2 months to provide consultation to practices. The Medical Home Advisory Committee met twice through the year and additional community groups such as faith-based organizations, mental health agencies, and representatives of ethnic groups were added to the advisory committee.

The CSHCN family advocate coordinator/executive director of Family Voices trained family advocates in the eight medical home practices and provided Medical Home presentations to ULEND trainees, community groups including nurses, families, professionals and support groups. She collaborated with the Utah Parent Center to include several pages on medical homes in their statewide newsletter UPC Connection. CSHCN administrative staff presented to professional groups such as the School Nurse Association, the directors of Utah Special

Educators, National Nurse Practitioners, residents, medical students and care coordinators at the local children's hospital. The coordinator published an article in the Utah Special Educator, a journal that is distributed to all teachers, schools and agencies in the state.

CSHCN continued to collaborate with the University of Utah Medical Center Department of Pediatrics to enhance the MedHome Portal http://medhomeportal.org. New modules were developed for the MedHome Portal website, including hearing screening, asthma treatment, infant mental health, screening for developmental disabilities, care coordination, and transition. Newsletters and transcripts of monthly practice phone conferences were posted on the website. In collaboration with the Ed/Med Committee (State Office of Education, school nurses, Title V, Utah Parent Center, Family Voices and teachers from each district) an education section for the website was developed which included two prototype forms for release of information between medical home and school, and a request form for physicians to communicate with schools regarding their special concerns. The website was presented at the University of Utah Pediatric Grand Rounds in November and subsequently published in the physician newsletter of the Primary Children's Medical Center.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop and implement a statewide system to support medical homes for children with special health care needs (CSHCN) in primary care settings				X
2. Participate in the National Initiative for Children's Health Quality (NICHQ) Medical Home Learning Collaborative and facilitate collaborative activities in 3 pediatric practice sites				X
3. Collaborate with University of Utah Department of Pediatrics to develop and expand the Medical Home Website to provide readily accessible supportive materials and resources				X
4. Identify and develop mechanisms to enable replication and sustainable support of Medical Home practices and Website				X
5. Provide support and ongoing education to pediatric offices established through the Utah Collaborative Medical Home Project and the NICHQ Learning Collaborative participating sites and continue Medical Home education efforts statewide				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Utah Collaborative Medical Home project (UCMHP) plans to continue to spread the medical home concept through ongoing collaboration with the University of Utah School of Medicine, specifically by supplementing the pediatric and family practice resident training curriculum. Regionally the plans include collaborating with the Intermountain Pediatric Society and the Utah chapter of the American Academy of Family Practice to investigate the best means of spreading the concept of medical home to the surrounding states. We continue to support the existing practice sites by continuing our current activities while looking for funds to

spread to additional sites. Title V intends to collaborate with the University of Utah Department of Pediatrics to develop strategies to improve access to specialty care.

The UCMHP team will expand the advisory committee to include representatives of more community organizations, cultural groups, families, faith-based organizations and physician specialists. We plan to continue development of the website by adding more diagnostic modules, e.g., a transition module, infant mental health and early intervention. The resource section will continue to be updated. Additionally, the project will increase collaboration with Early Intervention, the Infant Mental Health Committee, Newborn Screening, the State Asthma Advisory Committee, and other grant projects within the Bureau. A component of the genetics project includes spreading the concept of Medical Home concept through the training of the nurses, care coordinators and discharge planners at the local pediatric hospital.

We are working to increase Medical Home spread through changes to University of Utah, School of Medicine pediatric and family practice resident curricula and through collaboration with professional organizations. CSHCN is working with the University of Utah School of Medicine, Department of Neurology in implementing a subspecialty Medical Home project. In FY 05, the Medical Home team will sponsor a statewide medical home conference to provide support and training to new and existing medical home providers. CSHCN continues to support existing Medical Home sites through continuing current activities and finding funding mechanisms to support additional practices.

c. Plan for the Coming Year

The Utah Collaborative Medical Home project (UCMHP) plans to continue to spread the medical home concept through ongoing collaboration with the University of Utah School of Medicine (UUSM) and the Utah Chapters of the American Academy of Family Practice (AAFP) and American Academy of Pediatrics (AAP). The UCMHP will continue to support existing Medical Home practice sites and to develop additional sites. A MedHome Portal website conference will be hosted by Utah to discuss and promote collaboration with other key states who have previously expressed interest in participating in website use and spread. Invited attendees will include state CSHCN directors, representatives from AAP/AAFP chapters in the states, and leaders from the National AAP Medical Home Initiative, National Shriners' Hospitals, the Public Health Informatics Institute and the federal MCH Bureau. The UCMHP team will continue to promote the expansion of the advisory committee. Medical Home spread will also be promoted through changes to UUSM pediatric and family practice resident curricula and through collaboration with professional organizations.

In May 2005, the Bureau of CSHCN received an MCH "State Implementation Grant for Integrated Community Systems for CYSHCN." Through the Utah Integrated Services Project for Children and Youth with Special Health Care Needs, CSHCN will collaborate with the Utah Division of Health Care Financing (Medicaid), Utah Chapter, American Academy of Pediatrics, University of Utah Department of Pediatrics, Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ), Utah State University, and Utah Family Voices to develop a coordinated and responsive community-based system of services for Utah CYSHCN and their families through a systematic integration of services. Using the UMHCP as a cornerstone, the six core components of a quality system of care for CYSCHN will be integrated into Utah community systems, with emphasis on Medical Home, Family Involvement and Transition. A Youth Advisory Committee will be established. Community partners and practice teams will participate in a multi-phase Integrated Services Learning Collaborative (ISLC) focusing on provision of comprehensive care in the Medical Home model. The MedHome Portal will provide expanded information, resources, and services, including secure access to an online patient medical summary, "ask the care coordination specialist" service with a searchable archive of pediatric information. The Project will collaborate with "Utah Clicks" to expand on-line parent access to applications for numerous state and local programs. The ISLC will incorporate a participatory

action research approach in the design, implementation, and evaluation of the project. Grant activities will be integrated with the Utah Family Voices Family to Family grant, in the development of health coverage resources and training of new Family Voices advocates.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective				57.2	57.2
Annual Indicator			57.2	57.2	57.2
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	57.2	59	59	59	59

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are the data from the 2001 CSHCN SLAITS for this performance measure.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 57.2 and the Annual Indicator was 57.2.

With guidance from Federal CMS, the Utah Medicaid program was redirected from the original plan to submit a Pediatric Palliative Care program for children through an 1115 Research and Demonstration Project to working on and submitting a 1915c Home and Community Based Waiver Program. CSHCN has worked closely over the past year with Medicaid in the development of the 1915c Home and Community Based Waiver Program that will target children requiring end-of-life care in the community setting. The waiver application is near completion and will be submitted to CMS during this next year. The Home and Community Based Waiver program will provide access to Medicaid and additional support services for 30 children in the first year, 40 in the second and 50 in the third year.

Utah's Technology Dependent Waiver (Travis C. Waiver), administered through CSHCN, was able to increase the number served this past year from 110 recipients to 120. The increase has allowed access to Medicaid for 10 additional families without regard to parental income or assets. Additionally, information about accessing health care coverage and SSI was provided through the Medical Home Project's web-portal and staff to numerous primary care practices throughout Utah.

The CSHCN bureau director continued to participate on the Medicaid EPSDT Expanded Services and Prior Authorization Committee and the Utah Family Voices director continued to participate in the Medical Care Advisory Committee for Utah Medicaid. CSHCN continues to authorize diagnostic and treatment services for families who do not have health care coverage and worked closely with Primary Children's Medical Center, Shriners Hospitals for Children and other community organizations to additionally help cover medical costs for eligible children with complex health care needs that do not have access to public or private insurance. Social workers and other staff for CSHCN programs refer many families to the CSHCN on-site Medicaid eligibility worker for determination of eligibility. The on-site Medicaid eligibility worker has expertise in Medicaid eligibility for disabled children and works closely with partners in expediting the eligibility process for families served by CSHCN.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Track trends in insurance coverage for CSHCN			X	
2. Refer to Medicaid and CHIP Programs for eligibility determination		X		
3. Work with Medicaid and managed care organizations to develop programs to increase Medicaid insurance coverage for children with special health care needs, such as Waiver Programs and Administrative Case Management enhancements				X
4. Assist families in accessing and navigating health insurance coverage through the Medical Home and CSHCN programs		X		
5. Educate health care providers and support staff about resources available for families with CSHCN, including CHIP, Medicaid, Waiver Programs and Federal Supplemental Security Income (SSI) program			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN will continue outreach efforts to reach families who may be eligible for Medicaid and CHIP. Additionally, collaboration with PCMC, Shriners and other community organizations will occur to cover medical costs for eligible children with complex health care needs who do not have access to public or private health insurance.

CSHCN will continue to work with Medicaid during the implementation phase of Utah Medicaid's 1115 Research and Demonstration Waiver. CSHCN will also assist families to access health care coverage through the medical home project by educating health care providers and support staff about resources available for families of CSHCN, including

Medicaid, CHIP and SSI.

c. Plan for the Coming Year

CSHCN will continue outreach efforts through program staff with referrals made to the on-site Medicaid eligibility worker to reach families who may be eligible for Medicaid and CHIP. Additionally, the Bureau will collaborate with PCMC, Shriners and other community organizations to cover medical costs for eligible children with complex health care needs who do not have access to public or private health insurance.

CSHCN will continue to work with Medicaid during the implementation phase of Utah Medicaid's 1915c Home and Community Based Waiver program and assist in identifying families who may be eligible. CSHCN will also assist families with information on accessing health care coverage through the Utah Medical Home and Integrated Services Project for CSHCN. The Medical Home web-portal will be one avenue to educate health care providers and support staff about resources available for families of CSHCN, including Medicaid, CHIP and SSI. The CSHCN bureau director will continue to participate on the Medicaid EPSDT Expanded Services and Prior Authorization Committee and the Utah Family Voices director will continue to participate in the Medical Care Advisory Committee for Utah Medicaid.

Through the federal CMMS Family-to-Family grant for Family Voices grant and in-kind funding from the Bureau of CSHCN, Family Voices will collaborate with the Bureau and other family organizations to respond to the changing needs of families through the development of the Family-to-Family Health Information and Education Center in Utah. The Center will support families in accessing health and health-related information through a family run organization. Parent advocates will be trained and will support the Family Voices director in family advocacy activities. Additional volunteer parents will be trained in family support and will receive honorariums when they provide resource and advocacy information or consultation.

In 2004, Family Voices received an MCH Technical Assistance Grant, which supported the conducting of family focus groups related to Health Insurance and Funding as a result of the Survey on Children with Special Health Care Needs (SLAITS data). The Bureau of CSHCN and Utah Family Voices will use the findings of the focus groups to guide the development of information and teaching materials to support families and policy makers in insuring access for this population to adequate health insurance coverage.

Beginning in May 2005, CSHCN is participating in the Governor's Summit on the Uninsured, a statewide initiative for insuring that all Utahns have access to health coverage. This effort will continue into 2006, and the CSHCN bureau director and the Utah Family Voices director will participate in advisory groups that address the insurance needs of children, youth and adults with special health care needs.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004

Annual Performance Objective				79.1	79.1
Annual Indicator			79.1	79.1	79.1
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	79.1	82	82	82	82

Notes - 2002

The 2002 indicator is based on the State estimates from SLAITS.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are the data from the 2001 CSHCN SLAITS for this performance measure.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 79.1% and the Annual Indicator was 79.1%.

CSHCN provided information and referral to primary care providers and families directly and via the Medical Home web site and helped to improve the organization of community-based systems through the Utah Collaborative Medical Home project. CSHCN supported community-based access to specialty care through satellite case management and traveling clinics.

The CSHCN clinical programs, Neonatal Follow-Up Clinic, Child Development Clinic, Adaptive Behavioral and Learning Clinic, Hearing Speech and Vision Services and traveling clinics, augmented community clinical services and case management to ensure a coordinated system of care. Clinics worked closely with families, Medical Homes, schools and other community partners to coordinate specialty care for CYSHCN. Partnerships continued with the University of Utah Department of Pediatrics, PCMC and Shriners. CSHCN staff coordinated with community cultural agencies to improve access, as well as partner with community providers of health, education, vocational rehabilitation, and health care coverage to improve the coordination of comprehensive services. Newborn ICU data (mortality and morbidity) was recorded in a relational database and shared with all Utah newborn intensive care units.

The URADD project provided training and educational awareness for educators, community health providers, and the general public on ASD related topics and autism surveillance in Utah, in collaboration with the University of Utah School of Medicine's Department of Psychiatry's Utah Autism Research Program. Modifications to the URADD website were made to focus on resources for autism and developmental disabilities.

CSHCN provided case management to high-risk populations. 120 children who are dependent on specific types of technology and enrolled in the Travis Waiver Program received care coordination by registered nurses. The Fostering Healthy Children Program provided case management for 2000 children in Utah's Foster Care System. FHCP also worked with the

Immunization Program to increase the immunization rate of this population. Health Status Outcome Measures were redefined for Foster children, to enhance medical information tracking. FHCP also placed a nurse case manager in the State Emergency Shelter to improve continuity of care for children as they entered Foster Care.

The Baby Watch Early Intervention Program (BWEIP) experienced a budget shortfall for 2004 due to increased enrollment. The program narrowed program eligibility criteria to reduce caseload, and also instituted parent fees as a revenue source. BWEIP provided multidisciplinary services to infants, toddlers and their families through one statewide and 15 local programs. BWEIP provided training and technical assistance and lead in a collaborative effort to support the development of a system for mental health services for infants, toddlers and their families.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide information and referral to primary care providers and families of children with special health care needs about health care and other appropriate resources directly and through the Medical Home Website		X		
2. Provide multidisciplinary pediatric specialty evaluation and treatment services for children in Salt Lake City and in rural Utah that are not available from private providers	X			
3. Provide case management services to eligible children and families who are served by CSHCN clinical services, to children in Foster Care, to children who are technology dependent, to children who live in rural Utah and to children applying for SSI	X			
4. Improve the coordination of health care for CSHCN between the Medical Home and subspecialty care		X		
5. Partner with other community providers of health, education, vocational rehabilitation, and health care coverage to improve the coordination				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN will provide information and referral to primary care providers and families directly and via the Medical Home website and will improve the organization of community-based systems through the Utah Collaborative Medical Home project. CSHCN will ensure community-based access to specialty care through satellite case management and traveling clinics.

The programs will augment community clinical services, case management or capacity building efforts to ensure a coordinated system of care. Partnerships will continue with the University of Utah Department of Pediatrics, Primary Childrens Medical Center and Shriners Hospital. CSHCN staff coordinates with community cultural agencies to improve access, as well as partner with community providers of health, education, vocational rehabilitation, and health care coverage to improve the coordination of comprehensive services. The Newborn Follow-up

Program (NFP) is working to create a common database to connect perinatal, obstetrical and newborn intensive care unit data with NFP outcome data. Newborn ICU outcome data (mortality and morbidity) are recorded in a relational database and shared with all Utah newborn intensive care units.

The URADD project will provide training and educational awareness for educators, community health providers, and the general public on ASD related topics and autism surveillance in Utah, in collaboration with the University of Utah School of Medicine's Department of Psychiatry's Utah Autism Research Program. A physician survey will be completed. Modifications to the URADD website will be made to focus on resources for autism and developmental disabilities.

CSHCN will provide case management to high-risk populations. Children who are dependent on specific types of technology and enrolled in the Travis Waiver Program will receive care coordination by registered nurses. The Fostering Healthy Children Program will work with the Immunization Program to increase the immunization rate of this population. Work will continue to enhance the tracking of medical information and to increase the data gathered as children enter care.

The Baby Watch Early Intervention Program (BWEIP) experienced a budget shortfall for the SFY 2004 due to increasing demand for services. The program narrowed program eligibility criteria to reduce caseload, and also instituted parent fees as another revenue source. BWEIP will provide multidisciplinary services to infants and toddlers with disabilities and their families through one statewide and 15 local programs. BWEIP will provide training and technical assistance and lead in a collaborative effort to support the development of a system for mental health services for infants, toddlers and their families.

c. Plan for the Coming Year

CSHCN will provide information and referral to primary care providers and families directly and via the Medical Home web site and will improve the organization of community-based systems through the Utah Collaborative Medical Home project. Additionally, the CSHCN Bureau received an MCH "State Implementation Grant for Integrated Community Systems for CYSHCN." Through this grant, a systematic integration of community-based services will be promoted. CSHCN will ensure community-based access to specialty care through satellite case management and traveling clinics.

The CSHCN clinical programs, Neonatal Follow-Up Clinic (NFP), Child Development Clinic, Adaptive Behavioral and Learning Clinic, Hearing Speech and Vision Services and traveling clinics, will augment community clinical services and case management to ensure a coordinated system of care. Partnerships will continue with the University of Utah Department of Pediatrics, PCMC and Shriners. CSHCN staff will coordinate with community cultural agencies to improve access, as well as partner with community providers of health, education, vocational rehabilitation, and health care coverage to improve the coordination of comprehensive services. NFP is working to create a common database to connect perinatology, obstetrics and newborn intensive care unit data with NFP outcome data. Newborn ICU outcome data (mortality and morbidity) will be recorded in a relational database and shared with all Utah newborn intensive care units.

The Utah Registry of Autism and Developmental Disabilities (URADD) project will continue to obtain Utah prevalence rates and population estimates for Autism Spectrum Disorders and Development Delays. Additionally, the program will provide training for educators, community health providers and the general public on ASD topics and autism surveillance in Utah in collaboration with the University of Utah Department of Psychiatry's Utah Autism Research Program. A physician survey will be completed. Modifications to the URADD website will be made to focus on resources for autism and developmental disabilities.

CSHCN will provide case management to high-risk populations. Children who are dependent on specific types of technology and enrolled in the Travis Waiver Program will receive care coordination by registered nurses. The Fostering Healthy Children Program will continue to work with the Immunization Program to increase the immunization rate of this population. Enhancements will be made in tracking of medical information and to increase the data gathered as children enter foster care.

The Baby Watch Early Intervention Program (BWEIP) will continue to provide multidisciplinary services to infants and toddlers with disabilities and their families through one statewide and 15 local programs. BWEIP will provide training and technical assistance and lead in a collaborative effort to support the development of a system for mental health services for infants, toddlers and their families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transition to all aspects of adult life. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective					
Annual Indicator			5.8	5.8	5.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective					

Notes - 2002

Because only one of the States (Maine) met the NCHS standards for reliability for PM 6, the 2002 indicator is the national average except for Maine which has its State value noted.

Notes - 2003

The data reported in 2002 have pre-populated the data for 2003 for this performance measure.

Notes - 2004

The data reported in 2004 are the data from the 2001 CSHCN SLAITS for this performance measure.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 5.8% and the Annual Indicator was 5.8%.

Through the Utah Medical Home Collaborative Project a focus group was conducted on the subject of transition to adult care for youth with special health care needs. The participants in this group identified the following challenges in supporting transition of young adult with special needs: 1) lack of continuity of care between pediatric provider of care and adult provider of care, including adequate referral and notification of transfer as well as transfer of medical records; 2) lack of resources for older children and lack of knowledge about resources; 3) lack of internists trained in rare and complex conditions or in developmental delays; 4) inadequate reimbursement for efforts; and, 5) inadequate insurance for specialty care, especially mental health.

Utah continues to refine and improve the transition support system for children with special needs. The Utah Collaborative Medical Home web site transition module has been completed, providing on-line access to transition recommendations, resources and educational material developed by medical home providers and parents. Web materials were updated so the most current and comprehensive information is available. CSHCN continued to collaborate with Utah's Office of Special Education/Vocational Rehabilitation, the Division of Services to People with Disabilities, the Social Security Administration and Medicaid to organize and improve statewide transition services for young adults in our state. Additionally, CSHCN staff and the Medical Home Advisory Committee continued to develop strategies to improve the training and recruitment of providers such as "dual boarded" providers (pediatrics and internal medicine) and family practice providers to increase the numbers of medical homes as young adults transition out of pediatric services.

The CSHCN transition specialist provided direct transition planning for young adults and parents through CSHCN clinics. CSHCN staff work with youth and young adults who are not Bureau of CSHCN patients to provide them and their families information on accessing adult health and health related services. Training about transition service planning continued for CSHCN staff, family advocates, contract case managers and medical home providers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Develop Medical Home Website transition module, including transition resources		X		
2. Collaborate with Utah’s Special Education, Division of Services to People with Disabilities, Social Security Administration and Work Incentives Initiative staff to organize and enhance statewide transition services for young adults in Utah			X	
3. Conduct collaborative transition workshops for young adults and parents with Shriners Hospital for Children and the Intermountain Collaborative Transition Center			X	
4. Provide direct transition planning for young adults and parents through CSHCN clinics		X		
5. Provide training about transition service planning to CSHCN staff and family advocates		X		
6.				
7.				
8.				
9.				

10.

b. Current Activities

The Bureau of CSHCN continues to direct attention to the Medical Home Project, focusing on the development of the transition piece of the project's website. This website is designed to provide information that is critical for a successful transition to adult services, including information on funding of health care and other assistance, educational and vocational resources, employment or meaningful daytime activities, independent living, and emotional, spiritual and recreational activities.

CSHCN continues to promote collaborative efforts in the area of transition, working with the various state and Federal agencies including: State Office of Education, Division of Services for People with Disabilities, Vocational Rehabilitation, the Social Security Administration as well as the Work Incentive programs and Ticket to Work. CSHCN supports a transition specialist for services to itinerant clinic sites including Price, Moab, Blanding, Richfield and Vernal. These sites are largely rural and underserved and benefit from direct contact with the transition specialist. More than fourteen itinerant clinics will receive coordinated services from the transition specialist, which includes both on-site time at the clinics and follow-up and support between clinics via phone or telehealth. The CSHCN transition specialist will work with young adults and their families, local health department case managers, other local health care providers, as well as other agencies involved in the transition process.

The transition specialist will develop a list of health care providers that have indicated a willingness to provide primary health care to young adults. This activity and list supports the Medical Home Project work in the area of transition and helps to train and recruit providers to assume the health care of the young adult special needs population. Through the Medical Home project, CSHCN continues to work with family practice physicians to provide information and support in accepting into their practices children with special health care needs as they transition to adult health care. CSHCN will also be working with the University of Utah School of Medicine Department of Family and Community Medicine to develop Medical Home and transition training, which will be incorporated into resident physician training.

CSHCN staff continues to support the efforts of the Intermountain Collaborative Transitional Center in collaboration with Shriners Hospital for Children. CSHCN provides input regarding Shriners/Vocation Rehabilitation's "Work Preparedness" program as well as working with other community agencies that provide transition programs or community endorsed transition fairs or workshops. Staff continues to provide training and guidance to young adults and their families, both for identified children and youth with special health care needs and for inquiries from the general community.

c. Plan for the Coming Year

For FY 06, the Bureau of CSHCN will continue to focus on use of the Medical Home website's to further transition efforts among Utah's special needs children and young adults. The website is designed for ease of access and includes information critical for successful transition to adult services.

In an effort to assist the state's youth with special health care needs as they transition to adult services, the Bureau of CSHCN will collaborate and refer to the State Office of Education, Vocational Rehabilitation, the Social Security Administration, the Division of Services for People with Disabilities and Medicaid to facilitate each individual's access to comprehensive transition planning.

CSHCN's transition specialist will continue to travel to several itinerant sites to provide transition planning in Price, Moab, Blanding, Montezuma Creek, Richfield, and Vernal. These

rural Utah sites are underserved and present with significant transition challenges. In addition to on-site consultation with the transition specialist, phone consultation and support will continue to be ongoing throughout the state. In FY 06, fourteen or more clinics will receive on-site services from the CSHCN transition specialist and other rural site will benefit from phone consultation. The CSHCN transition specialist will work with young adults and their families, local health department case manager, health and mental health providers, educational institutions and other agencies in this process.

CSHCN staff will provide transition training and guidance to individual youth with special health care needs and their families, in collaboration with the Shriners Hospital for Children, directly or through transition fairs. CSHCN staff will also take inquiries from the community, regarding transition services for young adults, making appropriate referrals to other agencies.

Utah received MCH funding for the President's New Freedom Initiative: State Implementation for Integrated Community Systems for CYSHCN. Utah's Integrated Services grant will work to improve the system of care for Utah CYSHCN and their families at the community level while also creating a sustainable state infrastructure for the six MCH/CYSHCN core system components, with specific emphasis on Medical Home, Early and Continuous Screening and Transitions to Adult Health Care, Work, and Independence. Interventions proposed for this project are based on available evidence of best practices and/or emerging consensus of expert opinion, locally and nationally.

CSHCN will continue to work with family practice providers, throughout the state to provide education and support, facilitating the transition of youth with special health care needs from pediatric practices to family practice providers. CSHCN will continue to collaborate with the University of Utah School of Medicine Department of Family and Community Medicine to develop transition training for medical resident education.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	83	70	72	78	80
Annual Indicator	68	66.1	77.4	78.8	78.8
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance	80	80	80	80	80

Objective					

Notes - 2002

This measure does not have a numerator or denominator because it is taken from CDC's National Immunization Survey (NIS) which is only available at the state level as a percentage.

Notes - 2003

CDC's National Immunization Program (NIS), only state data available.

Notes - 2004

This measure does not have a numerator or denominator because it is taken from CDC's National Immunization Survey (NIS) which is only available at the state level as a percentage.

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 80% and the Annual Indicator was 78.8%.

Staff in the Utah Immunization Program worked with local health departments to ensure that the children with whom they come in contact were up to date on their immunizations for their age. Parents were encouraged to obtain the immunizations at their child's medical home.

The immunization registry, USIIS (Utah Statewide Immunization Information System), staff continued to work to complete the national certification process and HL7. USIIS outreach and enrollment staff in the Immunization Program provided training and support to USIIS users at all levels. Enrollment data were clarified and the private provider enrollment was 105.

Staff in the VFC Program actively recruited private health care providers to increase enrollment and to provide CASA/AFIX assessments through personal contact by program Provider Relations/Quality Assessment staff. Almost 300 providers (291) were enrolled in VFC and VFC CHIP. All components of administration of the VFC Program were assessed and improved to reduce barriers to physician involvement and to provide office-based CASA/AFIX assessments. CASA was done in 100% of provider offices.

The "Immunize by Two, It's Up to You" media campaign continued with its goal to raise awareness through education and information to remind parents of the importance of immunizing their children by age two. The campaign, in partnership with private business support, continued to use the media spots and targeted promotions with a focus on Infant Immunization Week. The campaign was complemented by the Hallmark two-month birthday card program.

WIC Program worked to improve immunization promotion activities in local WIC clinics, such as screening of WIC participants for immunization status, education on immunizations during WIC-required classes, and referral to the primary care provider for immunizations. Special emphasis was provided to outreach to special ethnic populations, especially to Native Americans. The mobile immunization clinic activities (Care-A-Van) were continued and provided 65 clinics statewide.

There are many reasons why Utah didn't meet the 80% NIS goal. A birth rate of 50,000, large family size, insurance issues, vaccine shortages and other competing demands conspired to keep the rate at 78.8%.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB

1. Work with all public and private providers to ensure that children are up-to-date with their immunizations			X	
2. Improve the Utah Statewide Immunization Information System (USIIS) by increasing provider enrollment and utilization				X
3. Improve the Vaccine for Children program by increasing provider enrollment and providing assessments to evaluate the proportion of children adequately immunized in their practice				X
4. Continue the Immunize by Two, It's Up to You media campaign to raise public awareness through education and information			X	
5. Collaborate with WIC to improve immunization education and referral			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Staff in the Utah Immunization Program will work with local health departments to ensure that the children with whom they come in contact are up to date on their immunizations for their age by encouraging the parents to obtain the immunizations at their child's medical home where possible.

The immunization registry, USIIS (Utah Statewide Immunization Information System), staff are continuing to work on completion of the national certification process including HL7 capability. USIIS, with the support of the VFC/AFIX Immunization staff, will roll out the registry applications and connections to more private providers and school districts. Training and support to users at all levels is being provided. The private provider enrollment goal for the year is 250. Providers are being encouraged to use the USIIS Web application WebKIDS.

Staff in the VFC Program continues to actively recruit private health care providers to increase enrollment and to provide CASA/AFIX assessments through personal contact by program Provider Relations/Quality Assessment staff. Increased emphasis has been placed on monitoring of appropriate vaccine storage and handling. The goal is to have 300 providers enrolled in VFC and VFC CHIP. All components of the VFC Program are continually assessed and improved to reduce barriers to physician involvement and to provide office-based CASA/AFIX assessments.

The "Immunize by Two, It's Up to You" media campaign continues with its goal to raise awareness through education and information to remind parents of the importance of immunizing their children by age two. The campaign, in partnership with private business support, continues to use the media spots and targeted promotions with a focus on Infant Immunization Week. The campaign has been complemented by the Hallmark two-month birthday card program. The Immunization Program continues to identify and develop public/private partnerships to promote the need for immunizations. These partnerships will include Office of Child Care, Licensing, PTA, WIC, local health departments, and community and migrant health centers.

The State WIC Program is continuing efforts to improve immunization promotion activities in local WIC clinics, such as screening of WIC participants for immunization status (4th DTaP), education on immunizations during WIC-required classes, and referral to the participant's primary care provider for immunizations. Special emphasis focuses on outreach to special ethnic populations, especially to Native Americans and Hispanic populations. The mobile

immunization clinic activities (Care-A-Van) are continuing in collaboration with local health departments.

c. Plan for the Coming Year

Staff in the Utah Immunization Program will work with local health departments to ensure that the children with whom they come in contact are up to date on their immunizations for their age by encouraging the parents to obtain the immunizations at their child's medical home where possible.

The immunization registry, USIIS (Utah Statewide Immunization Information System), staff will complete development of HL7 capability. Outreach and enrollment activities will be done with Provider Relations staff in the Immunization Program to provide training and support to users at all levels will be provided. The private provider enrollment goal will be 200. Providers will be encouraged to use the Web application WebKIDS.

Staff in the VFC Program will continue to actively recruit private health care providers to increase enrollment and to provide CASA/AFIX assessments through personal contact by program Provider Relations/Quality Assessment staff. Increased emphasis will be placed on monitoring of appropriate vaccine storage and handling. The goal is to have 300 providers enrolled in VFC and VFC CHIP. All components of the VFC Program will be assessed and improved to reduce barriers to physician involvement and to provide office-based CASA/AFIX assessments.

The "Immunize by Two, It's Up to You" media campaign will be continued with its goal to raise awareness through education and information to remind parents of the importance of immunizing their children by age two. The campaign, in partnership with private business support, will continue to use the media spots and targeted promotions with a focus on Infant Immunization Week. The campaign will be complemented by the Hallmark two-month birthday card program. The Immunization Program will continue to identify and develop public/private partnerships to promote the need for immunizations.

The State WIC Program will continue to improve immunization promotion activities in local WIC clinics, such as screening of WIC participants for immunization status (4th DTaP), education on immunizations during WIC-required classes, and referral to the participant's primary care provider for immunizations. Special emphasis will be outreach to special ethnic populations, especially to Native Americans and Hispanic populations. The mobile immunization clinic activities (Care-A-Van) will continue.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	24.2	24.1	24	17	16.5
Annual Indicator	21.2	18.5	17.5	16.0	16.0
Numerator	1271	1086	998	920	920

Denominator	60010	58746	57190	57349	57349
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	16	15.9	15.5	15.7	15.6

Notes - 2003

Numerator: Office of Vital Records and Statistics. UDOH. 2003
Denominator: IBIS Population estimates for 2003

Notes - 2004

Numerator: Office of Vital Records and Statistics. UDOH. 2003
Denominator: IBIS Population estimates for 2003

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 16.5 per 1,000 females age 15-17 and the Annual Indicator was 16.0 per 1,000 females age 15-17.

Births to Utah teens aged 15-17 years continue to decline, however rates are considerably higher among some subpopulations of teens. Staff in the Child Adolescent and School Health (CASH) and the Reproductive Health Programs collaborated with two local community coalitions (in Midvale and Glendale) working toward reducing their higher than average teen birth rates.

The Division published a comprehensive report on Adolescent Health in Utah, which included sections on Teen Sexuality and Teen Pregnancy. The report was widely disseminated and is available on the CASH website at http://www.health.utah.gov/cash/ Information and data on adolescent births in Utah are available on the Utah Department of Health's Internet Based Indicator System (IBIS) at http://ibis.health.utah.gov/view?xml=home/home.xml&xslt=home.xslt

The Maternal and Child Health Bureau continued to oversee MCH Title V funding for the Abstinence-only Education Program. The Adolescent Health Coordinator carried out oversight and technical assistance to the eight currently funded community-based projects. The projects utilized a number of creative strategies to promote abstinence from sexual activity, tobacco, alcohol and other drugs among youth aged 9-14 years.

Continued financial support of the Teen Mother and Child Program (TMCP) at the University of Utah was provided to assist teen mothers with optimal age-specific health care services and to help ensure that repeat teen pregnancies were avoided. Unfortunately, the repeat teen pregnancy rate in Utah continues to rise and strategies to address this concerning problem need to be identified in partnership with TMCP staff and teen mothers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	**ES**	**PBS**	**IB**
1. Disseminate a comprehensive report on Adolescent Health in Utah, including sections on Teen Sexuality and Teen Pregnancy				**X**
2. Oversee federal MCH funding for abstinence education to promote				

abstinence from sexual activity, tobacco, alcohol and other drug use among youth aged 9-14 years through a variety of methods that are sensitive to community needs and mores		X		
3. Develop a position for an Adolescent Health Coordinator to oversee adolescent health prevention and promotion activities				X
4. Provide support to the University of Utah Teen Mother and Child Program to assist teen mothers with optimal age-specific healthcare services and to help ensure that repeat pregnancies are avoided			X	
5. Provide district-specific data to local health departments regarding teen pregnancy and assist them in analyzing and reporting their data when requested				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Maternal Child Health Bureau continues to oversee MCH Title V federal funding for Abstinence-only Education Program. The Adolescent Health Coordinator is carrying out oversight and technical assistance to the currently funded community-based projects, which promote abstinence from sexual activity, tobacco, alcohol and other drugs among youth aged 9-14 years through a variety of methods that are sensitive to community needs and mores. The Adolescent Health Coordinator has developed a new RFP for FY06 funding that will open the funding to new projects.

Collaboration with Planned Parenthood Association of Utah continues to help to accomplish common goals of teen pregnancy prevention within the parameters of the state laws governing information and services to minors on contraception. The Reproductive Health Program has transferred appropriate publications to the Child Adolescent and School Health (CASH) website (http://health.utah.gov/cash) so that CASH staff can continue to develop and add appropriate links and resources related to adolescent pregnancy prevention. An extensive analysis of Utah teen pregnancy data, which will include new Pregnancy Risk Assessment and Monitoring System (PRAMS) data, is being conducted so that it can be updated and made available on the website this year. In addition, financial support of the Teen Mother and Child Program at the University of Utah continues to assist teen mothers with optimal age-specific health care services and to help ensure that repeat pregnancies are avoided.

c. Plan for the Coming Year

The Utah Abstinence Education Program will disseminate a request for proposals in a competitive process to allocate approximately $300,000 that the state receives to promote Abstinence Education among 9-14 year olds throughout the state. The proposals will be reviewed by a panel of experts from the Department and the community in order to stimulate new projects in areas of the state where need exists. The new contracts will be funded for FFY06 and upon successful completion of their project's goals and objectives, the contracts will be renewed as appropriate.

The Reproductive Health Program will continue to provide contract oversight for the MCH Title V Funding contracted to the Teen Mother and Child Program at the University of Utah for the provision of supportive, age appropriate prenatal and pediatric care to teen mothers. Contract specifications will be altered to assure that collaboration around the prevention of repeat teen

pregnancies is developed in an attempt to identify strategies that may be contributing to the increasing rate.

Continued collaboration between the CASH and Reproductive Health Programs and the neighborhood coalitions from Midvale and Glendale Utah will take place in order to identify strategies to reduce the higher than average teen birth rates in these communities.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	43	50	49.9	49.9	49.9
Annual Indicator	42.6	49.9	49.9	49.9	49.9
Numerator	164	252	252	252	252
Denominator	385	505	505	505	505
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	52	52	52	52	52

Notes - 2003

Utah Oral Health Survey 2000 Oral Health Program
CFHS, UDOH

Notes - 2004

Utah Oral Health Survey 2000 Oral Health Program
CFHS, UDOH

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 49.9% and the Annual Indicator was 49.9%.
During FY04, the Oral Health Program (OHP) promoted sealants through screening and referral activities, supported direct delivery of sealants at the local health department level, and conducted education/awareness programs with dental professionals, pediatricians and the public. The OHP concentrated on training local health departments on screening and referring procedures for children attending high risk elementary schools in their communities. The OHP continued to support and provide technical assistance to the Salt Lake Valley Health Department (SLVHD) in ongoing Sealant Saturday projects. SLVHD conducted two Sealant Saturdays in FY04 to place sealants on teeth of low-income uninsured and Medicaid insured children. The OHP also supported and provided technical assistance to sealant placement projects for low-income uninsured and Medicaid insured children coordinated and conducted by

the Dental Hygiene Program at Weber State University in Weber Morgan Health Department (WMHD). Sealant Projects in both SLVHD and WMHD included local health department and school personnel, volunteer dental hygienists, dentists, and dental assistants. A manual outlining a sealant project protocol/model to be used to assist additional local health departments and communities in implementing sealant projects through a cooperative effort between OHP and SLVHD had not been completed. The OHP, in collaboration with other state agencies and organizations such as Medicaid (EPSDT), CHIP and community health center dental clinics, promoted oral health prevention including sealant utilization to the public. Other activities included presentations and educational materials regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide technical assistance for local health departments to form local oral health task forces to address access to dental care				X
2. Train local health departments to screen children in at-risk elementary schools and refer for dental sealants and other needed dental treatment services				X
3. Develop strategies to reduce the percentage of children with untreated dental decay and increase the percentage of children with dental sealants using data from statewide survey of 6-8 year old children			X	
4. Support and provide technical assistance for free sealants projects to low-income and underinsured 6-8 year olds in Salt Lake and Weber Counties				X
5. Support the prevention and education activities of the Utah Oral Health Coalition and Salt Lake Valley Health Department in development of sealant project models to be implemented statewide			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY05, CFHS Oral Health Program (OHP) is promoting sealants through activities such as screenings and referral, support for direct delivery of sealants at the local health departments, and education/awareness programs for dental professionals, pediatric health care providers and the public. The OHP is concentrating on training local health department staff on screening and referral procedures for children in high-risk elementary schools in their communities. The OHP continues to support and provide technical assistance to the Salt Lake Valley Health Department (SLVHD) in ongoing Sealant Saturday projects. It is anticipated that SLVHD will conduct at least four Sealant Saturdays in FY05 for low-income uninsured and Medicaid-eligible children. The OHP also is supporting and providing technical assistance to other sealant placement projects for low-income uninsured and Medicaid-eligible children that will be coordinated and conducted by Dental Hygiene Programs at Weber State University, Salt Lake Community College, Utah Valley State College and Dixie College. Sealant projects in the Salt Lake Valley, Weber Morgan, Utah County and Southwest Utah Health Departments will

include, in addition to local health department and school personnel, volunteer dental hygienists, dentists and dental assistants. A manual outlining a sealant project protocol/model will be completed through a cooperative effort between OHP and SLVHD and used to assist additional local health departments and communities in implementing sealant projects. The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and community health center dental clinics, is promoting oral health prevention including sealant utilization to the public. Other activities have included presentations and distribution of educational materials regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

c. Plan for the Coming Year

During FY06, CFHS Oral Health Program (OHP) will promote sealants through screening and referral activities, support for direct delivery of sealants at the local health department level, and education/awareness programs among dental professionals, pediatricians and the public. The OHP will concentrate on training local health departments on screening and referring procedures for children attending high-risk elementary schools in their communities. The OHP will support and provide technical assistance in collaboration with the Salt Lake Valley Health Department (SLVHD) for the United Way of Salt Lake Michael Foundation funded "Sealants for Smiles" school-based preventive dental program. It is anticipated that more than 1,500 children will be screened and over 3,000 sealants placed in FY06 on low-income uninsured and Medicaid insured children. The OHP will also support and provide technical assistance to sealant placement projects for low-income uninsured and Medicaid insured children coordinated and conducted by Dental Hygiene Programs at Weber State University, Salt Lake Community College, Utah Valley State College and Dixie College. Sealant Projects in the Salt Lake Valley, Weber Morgan, Utah County and Southwest Utah Health Departments will include, in addition to health department and school personnel, volunteer dental hygienists, dentists and dental assistants. A manual developed through a cooperative effort between OHP and SLVHD that outlines a sealant project protocol/model will be distributed to be used to assist additional local health departments and communities in implementing sealant projects. The OHP, in collaboration with other state agencies and organizations such as the Utah Oral Health Coalition, Medicaid (EPSDT), CHIP and Community Health Center Dental Clinics, will promote oral health prevention including sealant utilization to the public. Other activities will include presentations and distribution of educational material regarding the benefits of sealants to dental professionals, pediatricians and other health care providers who have opportunities to promote and refer children for sealants.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	4.2	4.1	4	4.5	4.4
Annual Indicator	4.2	4.4	5.8	5.0	5.0
Numerator	25	27	36	32	32

Denominator	598299	609326	616927	638700	638700
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	4.9	4.8	4.7	4.6	4.5

Notes - 2003

Numerator: Office of Vital Records and Statistics. UDOH 2003
Denominator: IBIS Population estimates for 2003

Notes - 2004

Numerator: Office of Vital Records and Statistics. UDOH 2003
Denominator: IBIS Population estimates for 2003

a. Last Year's Accomplishments

This Performance Measure was not achieved. The Annual Performance Objective was 4.4 and the Annual Indicator was 5.0. While the motor vehicle death rate decreased from 5.8, even this substantial decrease was not enough to achieve the objective.

The Violence and Injury Prevention Program (VIPP) collaborated with numerous partners to develop and implement prevention strategies to reduce motor vehicle deaths among children. Motor vehicle safety information was available on the UDOH Internet site. A VIPP staff member participated in the State Pedestrian, Bicycle & Traffic Safety Council that investigated issues, established legislative priorities, and made recommendations regarding traffic safety. Over 54,000 English and 8,000 Spanish Utah Safe Kids Coalition newsletters, which dealt with motor vehicle safety topics, were produced and distributed statewide to hospitals, daycares, clinics, schools, and community health centers.

VIPP continued to provide funding, training, and technical assistance to all 12 local health departments to conduct motor vehicle safety and injury prevention programs including promoting occupant protection and bicycle and pedestrian safety. Examples of pedestrian safety activities include teaching pedestrian safety in schools, pedestrian safety promotion at worksites, and working to create safe pedestrian crossings. Over 80 pedestrian safety community events were held reaching over 52,000 individuals. Over 70 motor vehicle safety community events were held reaching over 30,000 individuals. Examples of activities include safety belt programs at schools, saved by the belt party for survivors, seat belt competitions between schools, scooter safety rodeos, participating on traffic safety committees, and activities to decrease drunk driving in the teenage and Hispanic populations. In addition, motor vehicle safety was promoted through media campaigns, city newsletters, educational booths, flyers, and articles in school newspapers.

During FY2004, VIPP coordinated a statewide pedestrian safety campaign. VIPP staff promoted Walk to School Day in over 95 elementary schools by working with Safe Kids Coalitions, local health departments, media, city governments, and businesses throughout the state. Over 40,000 people participated in the Green Ribbon Month program that was improved and promoted throughout the state to increase awareness of pedestrian safety. A pedestrian safety video was distributed to 54 elementary schools throughout the state. VIPP conducted presentations on safe routes to school to PTA members and Gold Medal School mentors. Also, pedestrian safety articles appeared in the media and on the UDOH Internet site. VIPP also assisted the new Driveway Danger Task Force to lower the number of children being injured and killed on driveways by motor vehicles.

Please see SPM3 on bicycle helmet use and SPM4 on child safety restraints for additional activities that were conducted.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with state and local agencies and community partners to implement strategies for reducing motor vehicle crash fatalities among children				X
2. Promote pedestrian safety events, such as Green Ribbon Month (September) and Walk to School Day (October)			X	
3. Provide motor vehicle safety education through presentations, community events, newsletters, the media, and the Internet			X	
4. Fund local health departments to conduct motor vehicle safety programs including promoting bicycle helmet use and child safety seats and seat belts, and providing pedestrian safety education for school-age children			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Violence and Injury Prevention Program (VIPP) continues collaboration with state and local agencies and community partners to develop and implement strategies for reducing motor vehicle crash fatalities among children in Utah.

Funding, training and technical assistance to each local health department are provided so that they can continue to conduct motor vehicle safety and injury prevention programs. These programs include promotion of bicycle helmets, child car seats, booster seats, and seat belts. In addition, education will be provided to school-age children on pedestrian, bicycle, and motor vehicle safety. Local health departments collaborate with community partners to accomplish safety promotions in their local communities.

VIPP continues to participate as a member of the Utah Department of Transportation's Traffic and Pedestrian Safety Transportation Committee by providing information and assistance. This committee investigates issues, exchanges information, establishes legislative priorities, and makes recommendations regarding traffic and pedestrian safety.

VIPP continues to develop and coordinate a pedestrian safety campaign to target drivers and pedestrians. Pedestrian safety events, such as Green Ribbon Month (September) and Walk to School Day (October), will be promoted. Pedestrian safety awareness is promoted by partnering with community organizations, distributing educational materials, working with the media, and providing information on the Department Internet site. VIPP continues to coordinate with the Utah Highway Safety Office and the Utah Department of Transportation on pedestrian issues regarding enforcement and the environment.

Please see SPM3 on bicycle helmet use and SPM4 on child safety restraints for additional activities that will be conducted to reduce motor vehicle crash deaths among children.

c. Plan for the Coming Year

The Violence and Injury Prevention Program (VIPP) will continue collaboration with numerous state and local partners to develop and implement strategies for reducing motor vehicle crash fatalities among children in Utah.

Funding, training, and technical assistance to each local health department will be provided so that they can continue to conduct motor vehicle safety and injury prevention programs. These programs will include promoting occupant protection, and bicycle and pedestrian safety. VIPP will continue to work with local health departments to support a coordinated statewide campaign to promote use of child safety seats. The campaign will include local public awareness and education activities in targeted communities, as well as car seat checkpoints in the targeted communities. Evaluation of this campaign will be based primarily on observation surveys conducted yearly in the target communities.

VIPP will continue to be a member of the State Pedestrian, Bicycle & Traffic Safety Council. VIPP will continue to develop and coordinate a pedestrian safety campaign. Pedestrian safety events, such as Green Ribbon Month and Walk to School Day, will be promoted. Partnering with community organizations, distributing educational materials, working with the media, and providing information on the UDOH Internet site will promote pedestrian safety awareness. VIPP will continue to coordinate with other agencies on pedestrian safety issues regarding enforcement and the environment.

Community education to increase bicycle safety will be continued through the media, distributing educational materials, submitting articles to newsletters, providing information on the UDOH Internet site, and teaching bicycle safety at schools and other community events. The program will continue to promote bicycle safety events, such as National Bike Month. VIPP will continue to seek sources for low cost bicycle helmets and make them available for distribution through local health departments, schools, law enforcement and other community partners. VIPP will continue to conduct its annual observation survey to estimate bicycle helmet use in Utah. The results of this survey and recommendations for improving helmet use will be shared with numerous interested parties.

Child car seat education and prevention efforts will include such activities as: conducting car seat and booster seat inspections; assisting with training sessions in local communities; facilitating the purchase and distribution of low-cost car seats; conducting safety education for school age children; working with the media; responding to requests for information by the public, professionals, legislators and others; supporting efforts to increase correct car seat use; and, providing information on the UDOH Internet website. The Utah Safe Kids Coalition will publish 120,000 newsletters that will be distributed to parents with motor vehicle safety tips and resources.

Performance Measure 11: *Percentage of mothers who breastfeed their infants at hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance	2000	2001	2002	2003	2004

Data					
Annual Performance Objective	86.4	86	86.2	85	85.1
Annual Indicator	85.9	86.6	84.9	85.5	85.5
Numerator					
Denominator					
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	83	84	85	85.5	86

Notes - 2002

The data reported this year are from the Ross Mothers' Survey. These data are only reported by percentage so no numerator or denominator is available for state level reporting.

Notes - 2003

The data reported are from the new National Immuniztion Survey. These data are only reported by percentage so no numerator or denominator is available for state level reporting. This is a new national data source. Previously Utah had been using the Ross Mothers' Survey.

Notes - 2004

The data reported are from the new National Immuniztion Survey. These data are only reported by percentage so no numerator or denominator is available for state level reporting. This is a new national data source. Previously Utah had been using the Ross Mothers' Survey.

a. Last Year's Accomplishments

The performance measure was achieved. The performance objective was 85.1 and the Annual Indicator was 85.5 using the results of the 2003 National Immunization Survey (confidence interval of +/- 4.3).

The CDC survey asked mothers in all 50 states if they "every breastfed". In previous years, the Ross Survey was used as the annual performance indicator because it was the only source of breastfeeding data available nationally. The CDC National Immunization Survey began piloting the breastfeeding questions in 2001 and many states now are using it as their Annual Indicator for the percentage of mothers who breastfeed their infants at hospital discharge. As a comparison, Utah PRAMS data (2003) indicated that 88.64% of women reported initiating breastfeeding.

Several activities were done during the year with the goal of increasing Utah's breastfeeding rates. The Utah WIC program continued to offer breastfeeding classes and support groups in local clinics. They also expanded the peer counseling program and significantly increased the training of staff and counselors. Recognizing that support was needed by women returning to either employment or school, WIC continued to distribute hand pumps and electric breast pumps; and expanded the equipment by 25%. WIC continued to deliver a message of encouragement and support of breastfeeding by expanding the breastfeeding education materials and making them available online for easy access and printing. The website includes more breastfeeding resources and materials including a self-paced client breastfeeding module. In clinics, clients and staff saw bulletin board messages, theme designs, information on where to get help, and the dissemination of World Breastfeeding Week information. WIC expanded worksite breastfeeding promotion at two worksites within the Utah Department of

Health to having 4 electric pumps available for employees. Lastly, promotion posters were placed in the Utah Department of Health Canon Building in areas where both the public and staff obtain vital records and other services.

The Reproductive Health Program also completed activities aimed at increasing Utah's breastfeeding rates. The PRAMS program released a Breastfeeding Newsletter that was mailed to care providers all over Utah. The newsletter included a statewide breastfeeding resource list. This was also presented at a display at the Utah Perinatal Association's annual meeting for perinatal healthcare providers. The WeeCare program continued to promote breastfeeding by providing a variety of printed materials and telephonic support to clients. During interviews with clients the WeeCare nurses discussed the options of continuing to breastfeed with mothers who planned to return to employment or school, and made a wider variety of breastfeeding educational materials available.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provide information to health care providers and the public about breastfeeding via publications, websites, and poster sessions			X	
2. Promote breastfeeding support to WIC enrolled women through peer counselors, classes, staff counseling, distribution of pumps and support groups		X		
3. Participate in activities of the “Utah Coalition to Promote Breastfeeding,” including promotion of breastfeeding support in workplaces throughout Utah			X	
4. Educate WeeCare clients about the benefits of breastfeeding by discussing infant feeding at initial interview and mailing educational materials, and over the phone postpartum lactation support		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program (RHP) continues to monitor breastfeeding trends among Utah women via PRAMS surveys, WeeCare participant surveys and WIC Nutrition Surveillance reports. These sources of information will help identify trends and determine needs for ongoing breastfeeding promotion activities. Reproductive Health Program continues to provide breastfeeding information to the public via its publications, website, and communications with local health departments and other community agencies. WIC continues to promote breastfeeding to increase the number of breastfeeding mothers in the WIC population, through a combination of strategies including: WIC Peer Counseling Trainings, updating and staff completion of the Breastfeeding Training Modules, sharing clinic bulletin board messages and theme designs and consistent information given during clinic classes on where to get help, providing World Breastfeeding Week information to each clinic, mailings and educational materials, and administering a survey to Utah WIC participants.

c. Plan for the Coming Year

Activities planned for the coming year will include many of the previously mentioned ongoing activities and additional strategies. The WIC Program will continue to increase the training of staff in breastfeeding support skills with a 40-hour Lactation Education course in August or November of 2005. WIC will complete a pilot program on the provision of a small electric breast pump for mothers returning to work combined with follow-up counseling, and compile results of the pilot. The WIC Program and the Utah Coalition to Promote Breastfeeding are planning a 2005 kickoff and bringing a nationally recognized speaker to a workshop titled "The Promotion and Practice of Breastfeeding". This speaker will also be presenting the following day at the University of Utah Obstetrics and Gynecology Grand Rounds. The WIC Program will be expanding to include CDC and USDA recommendations for breastfeeding data collection and participant services.

The PRAMS Program will continue to analyze and disseminate breastfeeding data. The questions asked in the survey address breastfeeding initiation and breastfeeding duration and the data will help in identifying characteristics of Utah women who choose to breastfeed and reasons women give for not initiating or for discontinuing breastfeeding. Identification of barriers will guide the WIC and Reproductive Health Programs in planning breastfeeding promotion, activities, and educational outreach.

The WeeCare Program will continue to monitor the breastfeeding rates of participants. The WeeCare nurses have found that many women who initially had planned to breastfeed did not actually do so; they will ask this group of women to share their experience of what led them to change their feeding plans and use this information in planning additional breastfeeding promotion activities. WeeCare will also follow-up with mothers who were undecided about their infant feeding method at the time of their enrollment to see if extra intervention and support will lead to increased breastfeeding rates with this group.

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	98	98	98	96.5	96.5
Annual Indicator	96.1	96.5	96.8	97.4	97.4
Numerator	46570	47325	48702	49740	49740
Denominator	48454	49041	50314	51069	51069
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	97.5	97.5	98	98	98

Notes - 2003

Numerator Source: Data were obtained from the Hearing, Speech, and Vision Services Program.UDOH
Denominator Source: Data are based on 2003 occurrent births obtained from Office of Vital Records and Statistics. UDOH.

Notes - 2004

Numerator Source: Data were obtained from the Hearing, Speech, and Vision Services Program.UDOH
Denominator Source: Data are based on 2003 occurrent births obtained from Office of Vital Records and Statistics. UDOH.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 96.5% and the Annual Indicator was 97.4%.

In FY04, Hearing, Speech and Vision Services (HSVS) improved newborn hearing screening through numerous activities. Hospitals screened 98.7% of 2003 births before discharge, with a 92.6 % pass rate (improved from 90% in 2002). Screening drops to 97.4% with home births added (since only 8% of the home births reported screenings in 2003). In 2003, sixty-two babies were identified with permanent congenital hearing loss, with an average age of diagnosis being 4.3 months.

The annual EHDI conference provided workshops on parent education, creation of brochures, diagnosis, follow-up, medical home, early intervention (EI), Hi*Track, best practice diagnostics, hearing aid fitting, and new research areas. Regional meetings emphasized effective screening and rescreening, MCH data integration, and improved data quality and management.

The state central database was upgraded to Hi*Track 3.5 for better data management in all but two sites. A new server links Hi*Track with the Child Health Advanced Records Management (CHARM) Data Integration Project. Diagnostic protocols reflect new national pediatric recommendations. An EHDI/EI training video was produced that focused on parent experiences from screening through diagnosis and referral to EI. This video was presented and distributed at the National EHDI conference, to Utah newborn screening, and EI programs. A parent brochure was developed to standardize newborn hearing screening and follow-up information. Work was started on a comprehensive Parent Resource Notebook.

A "Lost to Follow-up" study was conducted for program evaluation. Eight diverse sites participated based on ethnicity, size, urban/rural status, equipment used, and various staffing patterns. Surveys to parents and providers revealed: transportation and ESL barriers; lack of hospital resources; inefficient tracking of transferred babies and in-state births to out-of-state residents; and data entry errors as reasons for lost to follow-up. Future EHDI goals will address these issues with improved local partnerships and on-going education. Utah's Early Childhood Hearing Outreach (ECHO) Team was established and gave support to Head Start programs. HSVS audiologists provided ABR testing to rural/frontier areas through traveling clinics and home visits. Expansion of this service has helped decrease lost to follow-up rates and the age of hearing loss identification, especially with Native American populations.

A pediatric audiology listserv provided a forum for training and professional communication. Emphasis was on medical home coordination and improved follow-up and EI referral. A hearing loss module was developed for Utah's Collaborative Medical Home website which provides targeted information on pediatric management of hearing loss. Educational materials and program updates were sent to providers (MDs, audiologists) and community health centers.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Assist hospitals in using the Newborn Hearing Screening (NBHS) management and tracking system more effectively				X
2. Expand linkage of NBHS database to include early intervention				X
3. Improve NBHS, stressing increased outpatient completion rates, increased diagnostic reporting to the State, and timely Early Intervention enrollment by technical assistance, hospital participation through targeted site visits, and parent education			X	
4. Develop standardized hearing screening reporting protocols				X
5. Expand role of the Utah Consortium of Pediatric Audiologists in NBHS through regular communications via email, conference, and periodic site visits				X
6. Increase the provision of rural auditory brainstem response evaluations by regional audiologists			X	
7. Increase Utah primary care providers' participation in NBHS				X
8.				
9.				
10.				

b. Current Activities

The goal of the Hearing, Speech and Vision Services (HSVS) Newborn Hearing Screening Program is to screen all newborns for hearing loss before hospital discharge or by one month of age. Babies who do not pass initial screening are to have a diagnostic evaluation by three months. Babies with a hearing loss are enrolled in appropriate early intervention services by six months of age. Efforts are made to assure that every baby has a Medical Home. HSVS continues to provide training for hospital staff and regional audiologists involved in newborn hearing screening. Additional data training will be provided after the Hi*Track data system update is implemented. Continued efforts and additional resources continue to be committed to the Child Health Advanced Records Management (CHARM) data integration project. The expected outcome of these efforts is to improve identification, tracking, and reporting of hearing results statewide.

To support this goal, five primary issues are to be addressed in FY05: 1)through the CHARM Project, increased accuracy of tracking and follow-up will be accomplished through linkages with other state databases; 2) training activities will be increased to lay midwives to improve hearing screening for home births and birth center deliveries; 3) HSVS will train participating Early and Migrant Head Start programs to perform OAE hearing screening to further reduce the number of infants lost to follow up and improve identification and tracking; 4) HSVS will stress the importance of Medical Home coordination and expedient referral and follow-up of infants with permanent hearing loss. These collaborative activities enhance the goal of screening all newborns for hearing loss prior to hospital discharge; and, 5) CDC/EHDI research activities will be ongoing including: a) Economic Impact Study to accurately identify costs of newborn hearing screening and distribution across different sectors, both public and private since cost is a barrier to implementation of newborn screening programs. b) Genetic Analysis Study to provide information on the etiology of hearing loss through infants identified by newborn hearing screening. Babies failing newborn screening and then identified with a sensorineural or permanent conductive hearing loss are being offered a genetic evaluation. c) Cytomegalovirus Study (CMV) seeks to determine the contribution of congenital CMV infection to occurrence of sensorineural hearing loss in infants and establish the role of specific laboratory methods to

detect CMV infected infants. d) Loss to Follow-Up Study will identify factors responsible for loss to follow-up in EHDI programs and to develop successful and innovative strategies that will reduce loss to follow-up. Key stakeholders such as advisory committees, hospitals, parents, audiologists, physicians, and state EHDI and early intervention programs will help identify issues and solutions.

c. Plan for the Coming Year

The goal of the Hearing, Speech and Vision Services (HSVS) Newborn Hearing Screening Program is to screen all newborns for hearing loss before hospital discharge or by one month of age. Babies who do not pass initial screening will have a diagnostic evaluation by three months. Babies with a hearing loss will be enrolled in appropriate early intervention services by six months of age. Efforts will be made to assure that every baby has a Medical Home. HSVS will continue to provide training for hospital staff and regional audiologists involved in newborn hearing screening. Additional data training will be provided when the Hi*Track data system links to the Child Health Advanced Records Management (CHARM) project. Continued efforts and additional resources will be committed to the CHARM project. The anticipated outcome of these efforts is to improve identification, tracking, and reporting of hearing results statewide.

To support this goal, the following activities are planned for FY06: 1) Hospital referral rates will be reduced by providing 2-stage screening support, training activities and technical assistance to hospitals. Lay midwifery education will continue and a reporting system will be developed to better track home birth screenings. A quality indicator report will be developed for outpatient screenings. 2) The hospital/PIP (E.I.) project will be expanded at screening and diagnostic levels; audiology education will be scheduled through UCOPA; and new tracking strategies will be implemented resulting in more timely diagnosis of hearing loss. 3) Workshops will be held to update diagnostic technology and skills. An AAP EHDI presentation will be developed on the role of the physician in the EHDI process, making appropriate and timely referrals, and using the medical home to provide quality hearing health care. Diagnostic protocols will be updated and hearing aid fitting guidelines will be finalized. Current CDC economic, genetics and CMV studies will be completed and data used to improve EHDI systems and timelines from screening through intervention. 4) Loss to follow-up will be decreased by alerts to parents through the Birth Certificate application process and by increased documentation of audiological referrals. 5) HSVS will assure children with hearing loss have a medical home. EHDI resources will be added to HSVS and medical home websites, and capturing MD information through CHARM, and PIP enrollment data will be assessed. 6) The central data management system will convert to Hi*Track 4.0, with links to the CHARM system, hospitals will begin beta pilot tests of 4.0 and continued training and support will be provided to hospitals. CHARM implementation activities will increase accuracy of tracking and follow-up. Key stakeholders such as advisory committees, hospitals, parents, audiologists, physicians, and state EHDI and early intervention programs will help identify issues and solutions.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance	6.5	6.5	6	6.5	7.3

Objective					
Annual Indicator	6.5	6.5	6.8	7.3	8.2
Numerator	48620	50300	49800	54500	66800
Denominator	744557	769539	730417	742867	809865
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	8.1	8	8	8	8

Notes - 2003

Numerator: The proportion of children with no insurance calculated using the data from the Utah Health Status Survey 2003.
Denominator: IBIS Population estimates

Notes - 2004

Numerator: The proportion of children with no insurance calculated using the data from the Utah Health Status Survey 2004.
Denominator: IBIS Population estimates

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 7.3% and the Annual Indicator was 8.2%. At the same time that the State and National economies saw challenges, Utah saw an increase in the number of uninsured children.

During FY04, Division staff worked with the Covering Kids and Families Utah (CKU) Project, administered by Voices for Utah Children with funding from a Robert Wood Johnson grant, to improve access to health insurance. Staff participated on CKU workgroups addressing simplification, coordination, and outreach. Collaborative efforts led to a rule change that allowed families that were delinquent in CHIP premium payments to make back-payments and re-enroll within a one-year time period. Through committee work with the CKU Project, staff participated in developing and distributing outreach materials in English and Spanish to publicize Medicaid and CHIP income guidelines.

In coordination with the CKU Project, the Department of Health conducted a mass media campaign, including television, radio, print, and internet advertising including news releases and notices about CHIP Open Enrollment on the Utah Department of Health website. Staff notified and gave outreach materials to partner agencies through mailings, meetings, and electronic messages to publicize CHIP open-enrollment periods. The two open-enrollment periods, lasting for a total of 15 days, resulted in 20,299 registered applications, 9,267 approved applications, and 17,947 children enrolled in CHIP.

The School Nurse Consultant and other staff collaborated with the CHIP Outreach Coordinator to disseminate CHIP information and outreach materials to school district personnel. Home visiting nurses, funded in part through Title V funds, inquired about health insurance with all families and provided referrals when appropriate. The Healthy Child Care America/State Early Childhood Comprehensive Systems Grant Director participated in CKU Project and outreach activities and ensured that information was available to partner organizations including child care organizations.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work in partnership with Utah Children in conducting outreach programs for CHIP and Medicaid, simplifying enrollment and renewal processes and providing information to families to assist them in coordination of existing health care coverage				X
2. Collaborate with Utah CHIP in developing effective strategies to foster retention of CHIP children in the program				X
3. Collaborate with Utah Children to develop a web site with links to health care information that will be made available through local libraries, community technology labs, and government agencies for those without a home Internet connection				X
4. Disseminate CHIP and Medicaid outreach and referral information through local WIC clinics, immunization clinics, home visiting and Head Start programs, schools, and child care facilities				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY05, the Division of Community and Family Health Services staff continues to work with the Covering Kids and Families Utah (CKU) Project, Medicaid, and CHIP to collaborate closely in planning, implementing, and evaluating the effectiveness of outreach activities including those specifically designed to target special populations and ethnic groups. Voices for Utah Children, with funding from a Robert Wood Johnson grant, administers and coordinates the CKU project through community outreach activities in neighborhoods and schools through three community-based projects and partnerships with community agencies. The Division staff will work with the CKU Project to encourage CHIP and Medicaid outreach and referral through local clinics, home visiting and Head Start programs, schools, and child care facilities. Division staff will continue to participate on the three CKU workgroups to address 1) the simplification of CHIP and Medicaid application processes, 2) coordination of efforts with partners, and 3) outreach strategies to eligible populations. The CKU will explore options to address challenges of limited funding exacerbated by the depressed economy. The Division will work with the CHIP and Medicaid staff to promote outreach efforts.

The Utah Department of Health continues its mass media campaign, including television, radio, print, and internet advertising and evaluation of this campaign. The success of the internet portion will be strengthened with public relations and news releases about CHIP on the Utah Department of Health website. Utah Department of Health CHIP staff will conduct a grass-roots component that will include a mailing to many partners involved in reaching children prior to each open-enrollment period. Division staff attends CHIP Advisory Committee meetings, work with CHIP staff on collaborative projects, support policy changes that promote continuity of coverage, and disseminate information to partner agencies regarding changes in CHIP policies and open-enrollment periods. Prior to and during CHIP open-enrollment periods, the Division staff will disseminate information and outreach materials to local health department staff, school nurses, community partners, and the public through visits, mailings, and website postings. Through the Prenatal-5 Nurse Home Visiting Program, local health departments are

required to inquire about the health insurance status of children and identify strategies used to support the enrollment of children in various insurance programs. The Division staff will contribute to the development of new partnerships and distribute outreach materials through those partnerships.

c. Plan for the Coming Year

During FY06, the Division of Community and Family Health Services staff will work with the Covering Kids and Families Utah (CKU) Project, Medicaid, and CHIP to collaborate closely in planning, implementing, and evaluating the effectiveness of outreach activities. Voices for Utah Children, with funding from a Robert Wood Johnson grant, administers and coordinates the CKU project through community outreach activities in neighborhoods and schools through three community-based projects and partnerships with community agencies. The Division staff will work with the CKU Project to encourage CHIP and Medicaid outreach and referral through local clinics, home visiting and Head Start programs, schools, and child care facilities. Division staff will participate on the three CKU workgroups to address 1) the simplification of CHIP and Medicaid application processes, 2) coordination of efforts with partners, and 3) outreach strategies to eligible populations. With additional funding for CHIP from the State Legislature in FY 2006, Division staff will be involved with CHIP and the CKU Project to explore the possibility of expanding or modifying outreach efforts as CHIP is expected to increase the number of children enrolled.

The Utah Department of Health, including the CHIP Program, will continue its mass media campaign, including television, radio, print, and Internet advertising. The Department will evaluate the effectiveness of these methods. Division staff will attend CHIP Advisory Committee meetings, work with CHIP staff on collaborative projects, support policy changes that promote continuity of coverage, and disseminate information to partner agencies regarding changes in CHIP policies and open-enrollment periods. Prior to and during CHIP open-enrollment periods, the Division staff will disseminate information and outreach materials to local health department staff, school nurses, community partners, and the public through mailings, electronic messages, and links to news releases and other information on websites. Through the Prenatal-5 Nurse Home Visiting Program, local health departments will be required to inquire about the health insurance status of children and identify strategies used to support the enrollment of children in various insurance programs.

Performance Measure 14: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	71	72	74	81	81
Annual Indicator	79.8	80.4	78.5	78.5	88.0
Numerator	142227	97231	110002	110002	128196
Denominator	178149	120898	140176	140176	145683
Is the Data					

Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	88	88	88	88

Notes - 2003

Numerator: Used HEDIS data reported by the MCOs and fee for service claims to calculate the number of children receiving a service provided by Medicaid.
Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Health Status Survey 2003.

Notes - 2004

Numerator: Fee for service claims were used to calculate the number of unduplicated children receiving a service provided by Medicaid which included medical, dental and pharmacy claims.
Denominator: The number of children enrolled in Medicaid plus the proportion of children with no insurance who could have been eligible for Medicaid based on income for ages 1-18, were calculated using the data from the Utah Health Status Survey 2003.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 81% and the Annual Indicator was 88%.

During FY 2004, MCH and CSHCN Bureau nursing staff collaborated with Medicaid staff to improve outreach, access, quality, and use of services for children on Medicaid, including those with special health care needs.

Department staff participated in the Covering Kids and Families Utah (CKU) Project and encouraged local health clinics, home visiting programs, Head Start programs, school nurses, and child care providers to identify children and families needing services and to refer as appropriate. The Department worked with CKU staff to promote the design and distribute CHIP and Medicaid outreach materials that facilitate the identification and enrollment of eligible children.

The Child Adolescent and School Health Program (CASH) Program worked through the Early Childhood Council to develop links among the fragmented network of agencies, providers, and organizations left from the demise of the FACT(Families, Agencies, Communities Together) funding. The CASH Program provided consultation services for Medicaid programs including the Child Health Evaluation and Care Program (CHEC), Utah's EPSDT program, and the early childhood targeted case management service for children birth to three.

In FY 2004, the nurse consultant responsible for oversight of the Prenatal-5 Nurse Home Visiting Program provided technical assistance to nurses in local health departments to address challenges in implementing the Medicaid Early Childhood Targeted Case Management Service. The collaboration strengthened the coordination of the home visiting services to help assure that the services were continued and that Medicaid-eligible children were directed to existing health, developmental, and social services.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. Provide technical assistance and training for local health department home visiting nurses to assist families in accessing needed/appropriate health care for their infants				X
2. Work with CHIP staff and Utah Children to promote enrollment of Medicaid eligible children in Medicaid through outreach activities				X
3. Work with local health departments, CHIP, and Utah Children to assess gaps in the provision of services to Medicaid eligible children				X
4. Encourage local health departments, community health centers, school nurses, and child care providers to refer children and families for Medicaid eligibility determination			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY 2005, Division staff, including MCH and CSHCN Bureau staff, continue to collaborate with Medicaid staff to improve services to children. The Division staff will continue to work with the Medicaid Managed Health Care (MHC) Quality Assurance monitoring team on periodic Medicaid health plan reviews with the development of recommendations regarding methods for improving outreach, access, quality, and use of services for children on Medicaid, including those with special health care needs. Second, the Division will provide ongoing consultation services for Medicaid programs including the Child Health Evaluation and Care Program, Utah's EPSDT program. The Division staff will provide technical assistance addressing service challenges for local health department home visiting nurses conducting Medicaid's Early Childhood Targeted Case Management Service. These collaborative efforts will help improve services and direct Medicaid-eligible children to other existing health and developmental services.

Division staff continue to support the Covering Kids and Families Utah Project staff in encouraging local health clinics, home visiting and Head Start programs, school nurses, and child care providers to identify children and families needing services and to refer as appropriate. The Division staff works with the Covering Kids and Families Utah staff to promote the design and implementation of CHIP and Medicaid outreach activities and materials and support the training of eligibility workers to facilitate the identification and enrollment of eligible children in both CHIP and Medicaid. Additionally, the Division staff work with the Medicaid and CHIP Programs to support Utah Department of Health outreach activities.

During FY 2005 the Division, through the State Early Childhood Comprehensive Systems grant, the Early Childhood Council, and the Utah Pediatric Partnership to Improve Healthcare Quality, is exploring ways to develop links and collaborative projects among the fragmented network of agencies, providers, and organizations. These links and collaborative projects will seek to improve and increase services to Medicaid eligible children.

c. Plan for the Coming Year

During FY 2006, Division staff, including MCH and CSHCN Bureau staff, will collaborate with Medicaid staff to improve services to children. The Division staff will work with the Medicaid Managed Health Care (MHC) to improve outreach, access, quality, and use of services for children on Medicaid, including those with special health care needs. Second, the Division will

provide consultation services for Medicaid programs including the Child Health Evaluation and Care Program, Utah's EPSDT program. The Division staff will provide technical assistance addressing service challenges for local health department home visiting nurses conducting Medicaid's Early Childhood Targeted Case Management Service. These collaborative efforts will help improve services and direct Medicaid-eligible children to other existing health, developmental, and social services.

Division staff will provide ongoing support the Covering Kids and Families Utah Project staff in encouraging local health clinics, home visiting and Head Start programs, school nurses, and child care providers to identify children and families needing services and to refer as appropriate. The Division staff will work with the CKU staff to promote the design and implementation of CHIP and Medicaid outreach activities and materials and support the training of eligibility workers to facilitate the identification and enrollment of eligible children in both CHIP and Medicaid. Additionally, the Division staff will work with the Medicaid and CHIP Programs to support Utah Department of Health outreach activities.

During FY 2006 the Division, through the State Early Childhood Comprehensive Systems grant, the Early Childhood Council, and the Utah Pediatric Partnership to Improve Healthcare Quality, plans to explore ways to develop links and collaborative projects among the fragmented network of agencies, providers, and organizations. These links and collaborative projects will seek to improve and increase services to Medicaid eligible children.

Performance Measure 15: *The percent of very low birth weight infants among all live births.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	1.2	1.2	1.2	1	1
Annual Indicator	1.1	1.1	1.2	1.2	1.2
Numerator	515	505	571	614	614
Denominator	47331	47915	49140	49834	49834
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	1.2	1.2	1.2	1.2	1.2

Notes - 2003

Office of Vital Records and Statistics.UDOH 2003

Notes - 2004

Office of Vital Records and Statistics.UDOH CY 2003

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 1% and the Annual Indicator was 1.2%.

The rate of very low birth weight (VLBW) births continued to rise in Utah as in the nation as a whole due to the increasing rates of preterm births. This increase is partially attributed to an increase in the rate of multiple gestation births due to successful infertility treatments. During 2002, approximately 17% of Utah infants born preterm resulted from multiple gestation pregnancies. Although it is not known what percent of these births were related to artificial reproductive technology (ART).

The Reproductive Health Program completed an analysis using a linked Utah birth certificate and PRAMS data set for 1999-2001. Women who delivered live born singleton infants <37 weeks' gestation were categorized into either indicated or spontaneous preterm delivery groupings. The majority of preterm births were in the indicated category (53%), which were associated with medical and/or obstetric complications. The remaining 47% of preterm births were categorized as spontaneous, which occurred in women who had no identifiable contributing medical risk factors. These results were published in newsletter format and disseminated widely throughout the state. Recommended interventions derived from this analysis were related to the need for improved preconceptional health in reproductive aged women to help reduce preterm births categorized as indicated. These interventions could include education about preconceptional health, planning and spacing pregnancies, and provider practices that include screening all women of reproductive ages for health conditions that could affect future pregnancies.

The Division continued to collaborate with Medicaid on a study of the impact of periodontal disease prevention and preterm birth among the Medicaid population. The study has met with challenges in getting adequate numbers of women enrolled in the study, but hopes to be able to complete it in the upcoming year. The study's hypothesis states that pregnant women who receive a deep dental cleaning during their second trimester will have a lower preterm birth rate than demographically matched women who did not receive the deep dental cleaning.

The Division has implemented numerous strategies to promote smoking cessation among pregnant women including dissemination of educational materials through WIC clinics, health fairs, local health department clinics and community health centers. Screening and referral of pregnant women to smoking cessation treatment when they enroll in Medicaid by our partners in Medicaid continues to take place.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze data related to prenatal care to target affected population groups with appropriate interventions to improve prenatal care access in Utah				X
2. Disseminate information on the contribution of multiple births due to assisted reproductive technology to the very low birth weight rate			X	
3. Educate prenatal and oral healthcare providers and the public about the link between preterm birth and periodontal disease		X		
4. Disseminate smoking cessation educational materials for pregnant women in both English and Spanish through WIC clinics, health fairs, local health departments and community health centers			X	
5. Collaborate with Medicaid to screen and refer women to local smoking				

cessation treatment programs designed specifically for pregnant women		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program (RHP) will educate pregnant women regarding the "danger signs of pregnancy" through distribution of education materials to WIC clinics, community health centers, local health departments, health fairs and on the RHP website. In addition, the Utah PRAMS Project has incorporated oral health questions into the Phase V version of the PRAMS survey. These data and data from a Medicaid/Oral Health Program study will be analyzed to determine associations between periodontitis and premature births and will be disseminated to educate pregnant women, dentists, and prenatal care providers throughout the state.

The RHP and WIC programs continue to educate pregnant women and prenatal care providers about the relationship between very low birth weight (VLBW) births and inadequate weight gain during pregnancy and will catalog and provide information regarding nutrition counseling resources. In addition, the WIC program has added a goal setting component for each pregnant woman during her WIC certification visit.

PRAMS data related to VLBW preterm births will be analyzed, published and disseminated to appropriate health care providers and health systems administrators throughout the state. UDOH staff will continue to participate in the planning and implementation of the Utah Chapter of the March of Dimes (MOD) Prematurity Campaign. The MOD Prematurity Campaign Steering Committee is planning a Summit on Prematurity for the fall of 2004.

The Perinatal Task Force has been working on prematurity and low birth weight births in a subcommittee workgroup. It is expected that this subcommittee will develop recommendations to address the increasing rates.

c. Plan for the Coming Year

Considering that the analysis of Utah preterm birth data revealed that over half of the preterm births were indicated due to an obstetrical or a medical risk factor, preconceptional health appears to be an important contributor to the increasing rate of VLBW births in Utah. The Reproductive Health Program will collaborate with the Baby Your Baby Program to develop and implement a comprehensive public health education campaign around the importance of optimal preconceptional health. Television and radio spots as well as a variety of other appropriate social marketing methods will be utilized to educate women. The campaign will be implemented in both English and Spanish.

The analysis of Utah data preterm birth data also revealed that 17% of preterm births were as a result of multiple gestation pregnancies. The PRAMS survey has added questions related to Artificial Reproductive Technologies (ART) to its Phase V survey, which was implemented with 2004 births. These data will be analyzed to determine characteristics that are associated ART and potential strategies to address in future.

The MCH Bureau will continue to collaborate with the Utah Chapter of the March of Dimes in their Prematurity campaign. Several MCH staff members are participating on the planning committee for a prematurity campaign Summit for the fall of 2006. The purpose of the

campaign will be to increase community awareness around issues related to prematurity in Utah.

The Bureau will continue to address VLBW and prematurity through the efforts of one of the Perinatal Taskforce subcommittees whose work is focused on this issue. The subcommittee consists of UDOH staff and community partners who are committed to developing recommendations for interventions to address the increasing rate of VLBW births in Utah.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	13.5	12.2	12	12	11.9
Annual Indicator	12.4	11.9	13.2	14.4	14.4
Numerator	27	25	27	28	28
Denominator	217593	210312	204926	194145	194145
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	14.2	14	13.8	13.6	13.4

Notes - 2003

Numerator: Office of Vital Records and Statistics. UDOH 2003
Denominator: IBIS Population estimates for 2003

Notes - 2004

Numerator: Office of Vital Records and Statistics. UDOH 2003
Denominator: IBIS Population estimates for 2003

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 11.9 per 100,000 and the Annual Indicator was 14.4 per 100,000. The suicide deaths increased by one, which increased the rate from 13.7 to 14.4.

Under the direction of the Violence and Injury Prevention Program (VIPP), the Utah Youth Suicide Study (UYSS) was developed in 1997 to identify opportunities for prevention among adolescents. Of youth suicide cases studied (151), 89% of the subjects were male. The most common method of death was due to firearms. Of the cases, 26% had contact with the school system exclusively; 36% had contact with juvenile justice exclusively; and, 31% had contact with both the school system and juvenile justice. More importantly, 63% of all subjects had contact with juvenile justice (Gray et al., 2001).

Based on these findings, VIPP developed and implemented a Treatment Phase of the UYSS targeting at risk youth involved with the Third Juvenile Court District. The pilot project included screening and early intervention for selected juvenile offenders. This project was funded by a small award from the Commission on Criminal and Juvenile Justice. Participants were selected through a screening process conducted by Juvenile Probation officers. The criteria for participation included: 1) males aged 13-16 years; 2) referral by Juvenile Justice based on number of offenses between 2-12; and 3) a Youth Outcome Questionnaire (YOQ) score of >70 and a YOQ-PA score of <6. The YOQ measures symptoms of distress and dysfunction associated with a mental health diagnosis. The YOQ and Juvenile Justice recidivism and suppression rates were used as outcome measures. The treatment group received a psychiatric assessment and a 6-week intensive in-home family-based program provided by the Utah Youth Village. An individual treatment plan was developed and carried out through a core team that included the parents, an adolescent psychiatrist, a Utah Youth Village case worker and the Youth Suicide Study Coordinator. The control group completed the YOQ every 3 months and received the usual services available in the community that the parent chose. Each group received a small financial incentive for completing the YOQ.

The VIPP provides staff support and co-chairs with Dr. Doug Gray, the Youth Suicide Task Force. Implementation has begun on many of the activities of the Strategic Plan. The Strategic Plan was presented at the Utah Youth Suicide Prevention Conference. The VIPP continued its efforts to increase public awareness of youth suicide risks and prevention through public education and professional presentations at conferences, and by providing information on the UDOH Internet site. "Utah Youth Suicide Study: Latest Findings " was presented at the Annual Conference of the American Association of Suicidology. Analysis and dissemination of UYSS data continues.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Collaborate with the Suicide Prevention Task Force to revise and implement the Suicide Prevention Action Plan and continue efforts to identify and promote evaluation-based intervention programs in Utah				X
2. Educate public and professionals to increase awareness about youth suicide risks and effective prevention measures		X		
3. Analyze data and publish findings of the Utah Youth Suicide Study				X
4. Continue the Youth Suicide Prevention Pilot Study, which includes screening and early intervention for at-risk youth involved in the juvenile justice system; and disseminate findings when available	X			
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Violence and Injury Prevention Program (VIPP) continues its work with the Youth Suicide Task Force (YSTF) to revise the Suicide Prevention Action Plan and continue efforts to identify

and promote evaluation-based intervention programs in Utah. The area of youth suicide will become part of the comprehensive Strategic Plan for Injury and Violence Prevention rather than remain separate from the statewide plan.

To increase public awareness about youth suicide risks and prevention, VIPP will continue to work with the YSTF to provide information to the media, conduct professional and community presentations at local and state conferences, and provide information on the UDOH Internet site.

VIPP staff continues collaborative efforts with partners in the YSTF to look at evaluation-based intervention programs around the country in order to implement similar programs in Utah. Preliminary findings of a study conducted by the Utah Department of Health indicated that a majority of Utah teens who committed suicide had some history with the juvenile justice system and/or a history of mental health problems. This finding suggests that improved screening of youth in the juvenile justice system may yield opportunities for early identification and intervention for youth who are at higher risk of suicide. The Program will continue a pilot study for screening and early intervention with high-risk youth.

VIPP continues to work in partnership with the Child Fatality Review Committee to review youth suicides in order to enhance the quality and quantity of data available on suicide so that the data can be used for prevention purposes. Data collection will be used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high-risk populations for interventions, and to assess the impact of prevention efforts.

Violence and Injury Prevention Program works with its partners to educate the public about the need for appropriate locked and unloaded firearms storage. VIPP promotes the ASK Campaign (Asking Saves Kids), which is a national campaign that encourages parents to ask their neighbors if they have a gun in the home before sending their children to that home to play. Local health departments conduct educational programs such as "Gunwise" utilizing Title V funding to make parents aware of their personal responsibility for proper storage of guns in their homes.

c. Plan for the Coming Year

The Violence and Injury Prevention Program (VIPP) will transition the work with youth suicide prevention activities to the Child Adolescent and School Health (CASH) Program in the Maternal and Child Health Bureau during FY2006. CASH will be hiring a children's mental health specialist who will work part time on youth suicide prevention and continue efforts to identify and promote evaluation-based intervention programs in Utah. Youth suicide prevention is a component of the State Strategic Plan for Injury and Violence Prevention and VIPP will continue to work with CASH by providing data and other assistance. Once the CASH Children's Mental Health Specialist is hired, the CASH Program will develop a plan to address youth suicide prevention

The Youth Suicide Task Force (YSTF) will be reassigned to the CASH Program for staff support. Efforts to increase public awareness about youth suicide risks and prevention will continue. The Intermountain Injury Control Research Center (IICRC) and other YSTF members will provide information to the media, conduct professional and community presentations at local and state conferences, and VIPP will continue to provide information on the UDOH Internet site.

Preliminary findings of a study conducted by the UDOH and the University of Utah indicated that a majority of Utah teens that committed suicide had some history with the juvenile justice system and/or a history of mental health problems. The pilot study for screening and early

intervention with high-risk youth will be concluded 6/30/05. The IICRC will conduct the data analysis and VIPP will be involved in reviewing and publishing the results. The YSTF approved Dr. Gray and the IICRC to apply for a federal Garrett Lee Smith grant to expand the juvenile justice pilot study to other court districts in the state.

VIPP will also continue to work in partnership with the Child Fatality Review Committee to review youth suicides in order to enhance the quality and quantity of data available on suicide so that the data can be used for prevention purposes. Data collection will be used to track trends in rates, to identify new problems, to provide evidence to support activities and initiatives, to identify risk and protective factors, to target high-risk populations for interventions, and to assess the impact of prevention efforts. VIPP has received and is implementing a National Violent Death Reporting System grant. This database will collect information on all violent deaths including suicides. In addition, a state specific module is being developed to collect additional suicide data that the CFRC and the Youth Suicide Study have identified as important to collect. Data for calendar year 2005 deaths will be collected during FY06.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	78	81	84	70	71
Annual Indicator	80.3	67.3	66.0	63.2	63.2
Numerator	456	340	377	388	388
Denominator	568	505	571	614	614
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	64	66	68	70	72

Notes - 2003

Office of Vital Records and Statistics. UDOH 2003
The number of hospitals classified as level III decreased by one over the reporting period.

Notes - 2004

Office of Vital Records and Statistics. UDOH 2003
The number of hospitals classified as level III decreased by one over the reporting period.

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 71% and the Annual Indicator was 63.2%.

The percentage of very low birth weight (VLBW) infants delivered at tertiary facilities for high-risk deliveries and neonates continues to decline in Utah, due in part to a change in the number of hospitals classified as level III compared to previous years. One hospital formerly classified as level III was reclassified as a level II facility because it doesn't have perinatal specialists on staff. Another hospital is be added in 2005 due to its new staffing support of perinatology and neonatology. The rate may also be decreasing due to the increasing rate of non-viable preterm births in the <500 gram category which doubled in the past decade (0.08% to 0.16%).

Of the VLBW infants who were born outside tertiary centers, 15.5% were <500 grams and most probably non-viable, therefore the decision not to transport mother prior to delivery was likely appropriate. VLBW infants weighing between 1000-1499 grams and were born outside tertiary care comprised 32.7% of the total number of infants in this weight group. Infants in this category of birth weight may be receiving acceptable neonatal care in level II nurseries that have a staff neonatologist and nurses experienced in caring for premature infants at this stage of development. The remaining 51.8% of VLBW infants with weights in 500-999 gram category are of the greatest concern. These infants very clearly should be delivered in a tertiary center. In analyzing data on this group of VLBW infants more carefully, over 63.6% (68) of them delivered at an out of state hospital, perhaps to women who reside near Utah's borders in Arizona or Colorado; 9.4% (10) delivered at a level II hospital with a neonatologist on staff, but not equipped (according to Utah code R432-100-17) to care for infants at this category of VLBW. The remaining 27.1% (29) of VLBW infants born outside tertiary centers were equally distributed among seven level II hospitals and could be as a result of a precipitous preterm delivery during which there was insufficient time to transport mother prior to delivery. Of the 500-999 gram VLBW infants born outside tertiary care hospitals for whom we have data, 85.3% (93) survived the immediate neonatal period and of these only 14% (13) were transferred to a tertiary care center following birth; slightly over 48% (45) of this group of infants remained in the level II hospital where they were born. Data were missing on the other 35 infants.

The Reproductive Health Program and MCH Bureau staff collaborated with the UDOH Bureau of Licensing to amend rule 432-100-17 of the Utah Code, which deals with Perinatal Services in Utah hospitals. The amendment process provides for a public comment period, during which several Utah hospitals provided feedback and awareness around the importance of VLBW infants being delivered at facilities for high-risk deliveries and neonates was publicized.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Rewrite the Utah code on hospital nursery standards to ensure hospital nurseries throughout the state are compliant				X
2. Collaborate with Department’s Bureau of Licensing to ensure hospitals are compliant with the Utah code for nursery standards				X
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

Intermountain Health Care (IHC), the largest integrated health care system in Utah, owns almost half of the delivery hospitals in the state with a network of over 3,000 health care providers. As a result of the Utah Code amendment of rule 432-100-17, the Director of IHC's Women and Infant Services has been collaborating with the UDOH MCH Bureau Director and the Reproductive Health Program Manager for input into revising IHC's Perinatal Program Standards for neonatal and obstetric hospital care to better reflect the new rule requirements. Although these revised standards will still most likely result in some VLBW babies being delivered at level IIB hospitals (3), they should go a long way toward improving the hospital standards for these VLBW infants. Continued collaboration to assess the impact of these revised standards will be ongoing.

Because the other half of the delivery hospitals throughout the state are owned by other corporations or a government entity, dissemination of the amended rule regarding Perinatal Services is needed. The Reproductive Health Program will publicize the rule change among non-IHC delivery hospitals and serve as a resource to clarify questions that may arise. Continued surveillance of the VLBW births that occur outside facilities for high-risk deliveries and neonates is needed. The Reproductive Health Program will analyze birth and neonatal data on VLBW infants born in non-IHC facilities in the state to determine appropriateness of these delivery decisions.

Although the rule change should help to clarify expected standards of perinatal care for delivery hospitals throughout the state, market factors exist that may influence hospitals' decisions regarding delivery of VLBW infants in non-tertiary care facilities. Because of this the MCH Bureau and RHP will facilitate compliance to the amended Utah code R432-100-17 rule for Perinatal Services through continued collaboration with the UDOH Bureau of Licensing to assure optimal outcomes for VLBW infants in Utah.

c. Plan for the Coming Year

The Reproductive Health Program will focus on VLBW infants in the 500-999 gram weight category who were born outside tertiary care centers to determine factors that may have contributed to the decision not to transport their mothers to a more appropriate facility to deliver. Following analysis of these data, partnerships with the level II hospitals where these deliveries occurred will be established with the goal of determining how to reverse these decisions, since research that links neonatal outcomes with levels of perinatal care indicate that morbidity and mortality for very low birth weight (VLBW) infants are improved when delivery occurs in a subspecialty facility rather than a basic or specialty facility even after adjustments for severity of illness. (Blackmon, 2003)

The new American Academy of Pediatrics policy statement entitled Levels of Neonatal Care (Stark, et al 2004) will be publicized by Reproductive Health Program staff among hospital nursery administrators so that Utah facilities that provide hospital care for newborn infants have current knowledge necessary to ensure that each newborn infant is delivered and cared for in a facility appropriate for his or her health care needs and to facilitate the achievement of optimal outcomes.

REFERENCES:

Blackmon L. The role of the hospital of birth on survival of extremely low birth weight, extremely preterm infants. NeoReviews. 2003;4 :e147 --e157

Stark A., et al. Levels of Neonatal Care. Pediatrics. 2004 Nov;114 (5):1341-1347.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	77.5	78	78.5	78.2	78.4
Annual Indicator	77.1	78.2	78.0	78.0	78.0
Numerator	36509	37454	38324	38886	38886
Denominator	47331	47915	49140	49834	49834
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	78.6	78.8	79	79.2	79.4

Notes - 2003

Office of Vital Records and Statistics. UDOH 2003

Notes - 2004

Office of Vital Records and Statistics. UDOH 2003

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 78.4% and the Annual Indicator was 78.0%.

The Perinatal Task Force, comprised of representatives from local health districts, community health centers, perinatal health care providers, public health schools, third party payers, and other organizations, met to seek solutions to this problem. Prenatal care was one of four priorities the Task Force will work on over the next 12 months. A subcommittee was formed to specifically address adequacy of prenatal care.

The Department implemented a new theme for the Baby Your Baby campaign "13 by 13" (first visit by 13 weeks and 13 visits before delivery) campaign in media and print. Three commercial spots were aired on the local CBS affiliate and on radio stations throughout the state encouraging women to get early and continuous prenatal care. The Baby Your Baby by Phone Program processed 1,723 presumptive eligibility applications for women in Salt Lake County, a slight decrease from FY03.

The Division collaborated with the newly developed Medicaid Early Childhood Targeted Case Management Services for Medicaid-enrolled children up to age four to promote dissemination of information regarding the importance of early prenatal care. The Reproductive Health Program continued its support of a lay outreach program with the Weber-Morgan Health Department and the March of Dimes in downtown Ogden. However, grant funding for the program ended and the Weber Morgan Health Department chose to discontinue it. To support early prenatal care among uninsured women, the Division continued its contract with Salt Lake

Community Health Centers, Inc. to provide funds for prenatal care services for uninsured women, many of whom are women of undocumented citizenship status. The Division was unable to do much to provide education services regarding prenatal care with halfway houses due to lack of interest and divided opinions as to which agency was responsible for these services. Two local health departments, Weber-Morgan and Salt Lake Valley, had already established partnerships with local jails and were providing services to pregnant women.

The Division worked on an on-line presumptive eligibility application, targeted to begin in October 2004, which will allow women to fill out a PE application via the Internet and prequalify for presumptive eligibility automatically.

The RHP added PRAMS phase V questions on timing of Medicaid coverage to assess how insurance impacts entry rates.

In an effort to reduce the number of birth certificates lacking information on entry into prenatal care, the Division collaborated with the Department's Office of Vital Records and Statistics efforts to improve reporting. The RHP worked with Vital Records staff to develop training for hospital records staff to improve reporting of prenatal care information.

Figure 4a, National Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Analyze 2000 Pregnancy Risk Assessment and Monitoring System (PRAMS) data to better understand barriers to early prenatal care entry				X
2. Disseminate new Baby Your Baby campaign and messages that promote early and continuous prenatal care		X		
3. Work with lay outreach workers in Ogden to educate women on the importance of prenatal care			X	
4. Work with the Perinatal Task Force to develop strategies to address barriers to prenatal care			X	
5. Work with Department’s Vital Records staff to improve the quality of birth certificate data regarding prenatal care entry and number of visits				X
6. Offer the Baby Your Baby by phone program to ensure that pregnant women in SL County have access to determination of eligibility for health coverage for prenatal care			X	
7.				
8.				
9.				
10.				

b. Current Activities

During FY2005, analysis of PRAMS data to determine women's perceived barriers to early prenatal care has been done and results are being utilized in the development of outreach strategies. The Perinatal Task Force, which was organized to seek solutions to Utah's poor adequacy of prenatal care rating, continues to assist with formation and implementation of strategies to address barriers to early entry.

Through collaboration with Baby Your Baby, appropriate public outreach approaches are being developed to promote early entry into prenatal care. The Baby Your Baby by phone program

continues to accept presumptive eligibility applications via phone interview. On-line submissions of presumptive eligibility will be implemented.

The Division will collaborate with the Office of Vital Records and Statistics to address the issue of poor prenatal care data due to women who transfer care providers during pregnancy.

The Division collaborates with the Child Adolescent and School Health Program staff on its prenatal to five home visiting programs for at-risk families with infants to promote dissemination of information to participating families regarding the importance of early prenatal care.

In an effort to increase early prenatal care participation among uninsured women, the Division has continued its contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women without third party payers, many of whom are women of undocumented citizenship status.

The RHP continues to work with the Baby Your Baby Advisory Committee, IHC, KUTV, and Bonneville Media to continue the "13 by 13" (first prenatal visit by 13 weeks and 13 visits before delivery) campaign in media and print. A survey has been conducted of women who recently delivered a baby to determine if the 13 by 13 campaign is successful in modifying women's perceptions of the importance of early and ongoing prenatal care.

c. Plan for the Coming Year

The MCH Bureau will work on analyzing results of the BYB campaign evaluation to see if the campaign was successful in getting women into early and adequate prenatal care. Randomly selected women who recently delivered a live birth were sent a survey and 620 completed surveys were returned. The analysis will focus on whether or not the campaign motivated women to seek early and continuous prenatal care.

The Division will continue to collaborate with the Child Adolescent and School Health Program staff on its prenatal to five home visiting programs for at-risk families with infants to promote dissemination of information to participating families regarding the importance of early prenatal care.

In an effort to increase early prenatal care participation among uninsured women, the Division will continue its contract with Salt Lake Community Health Centers, Inc. to provide funds for prenatal care services for women without third party payers, many of whom are women of undocumented citizenship status.

Through collaboration with Baby Your Baby, appropriate public outreach approaches will continue to be developed to promote early entry into prenatal care. The Baby Your Baby by phone program will continue to accept presumptive eligibility applications via phone interview. On-line submissions of presumptive eligibility will be accepted when the system is running.

The RHP will work with Intermountain Health Care to establish more Baby Your Baby sites in rural hospitals. Women could then be screened in the hospital for BYB and approved on site. This expedited application process will be very beneficial to those women who appear in the emergency room.

The prenatal care subcommittee of the Perinatal Task Force will continue to meet and formulate and implement strategies to increase prenatal care entry and adequacy. Two areas the group will investigate is disseminating information regarding low cost or sliding scale prenatal care to the State's information and referral networks. The group will also investigate the potential use of electronic prenatal care records. Lastly, the group will look at education strategies surrounding recognition of pregnancy, which PRAMS respondents listed as a reason

for late entry into prenatal care.

D. STATE PERFORMANCE MEASURES

State Performance Measure 1: *The percent of children with special health care needs in the rural areas of the state receiving direct clinical services through the state CSHCN program.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.5	11.0	11.5	12.0	12.5
Annual Indicator	10.5	11.4	11.7	12.9	13.4
Numerator	2336	2529	2327	2583	2742
Denominator	22227	22113	19909	20035	20502
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	13	13	13.5	13.5	13.8

Notes - 2003

Numerator: The number of children served in the rural area based on the Mega West billing system.
Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS. 11.2%

Notes - 2004

Numerator: The number of children served in the rural area based on the Mega West billing system.
Denominator: Estimated proportion of CSHCN children in the rural areas based on SLAITS. 11.2%

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 12.5% and the Annual Indicator was 13.4%.

The Bureau of CSHCN contracted with five satellite local health departments to continue itinerant clinics in nine sites across the state. Through these contracts, registered nurse care coordinators and clerical staff scheduled clinics, complete encounter forms, send out appointment letters, call families, provide care coordination services, arrange tests, collect reports and maintain patient charts. Due to budget cuts in 2004, responsibilities for the contracts and itinerant clinics were transferred to the two clinical programs that staff the clinics: the Child Development Clinic (CDC) and the System Development Program (SASS). Through managers in these programs, CSHCN continued to provide ongoing support and training on

care coordination issues to the satellite contract and program staff. CSHCN updated the Access software database used by each site to schedule clinics and collect patient data. Information on resources and clinical processes was provided.

The Community-Based Services Newsletter was discontinued to be replaced by the Medical Home newsletters and reminders to visit the Medical Home Website. Chart audits were conducted and recommendations were made for process improvement at the satellite sites.

The CSHCN Bureau continued its efforts to provide clinic follow up to rural children with special health care needs through Telehealth community conferences. These conferences use videoconference technology currently in place through the University of Utah Telehealth Network. Additionally, the Utah Collaborative Medical Home practice sites were encouraged to link and network with the nurse case managers in the rural satellite offices.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Continue multidisciplinary specialty services in nine rural clinic sites for children with special health care needs, families and providers	X			
2. Maintain case managers and support staff in nine rural areas across the state				X
3. Increase Telehealth activities (which relate to video communication between CSHCN providers in the urban areas and families/children and other community providers in the rural areas)	X			
4. Improve the coordination of health care for CSHCN between the Medical Home and subspecialty care providers				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Bureau of CSHCN is contracting with five local health departments to continue itinerant clinics in nine sites across the state. Due to budget cuts in 2004, responsibilities for the contracts and itinerant clinics have been transferred to the two clinical programs that staff the clinics: Child Development Clinic (CDC) and System Development Program (SASS). Through the contracts, local registered nurse care coordinators and clerical staff schedule clinics, complete encounter forms, send out appointment letters, call families, provide care coordination services, arrange tests, collect reports and maintain medical charts. CSHCN provides ongoing consultation and support on care coordination issues to contract staff. CSHCN supports an Access software database used by each site to schedule clinics and collect patient data. Information on resources and clinical processes will be provided.

CSHCN continues to work to integrate local rural clinic activities into the statewide Medical Home effort, and works closely with local primary care medical home providers to coordinate the care for children. Chart audits will be conducted and follow-up from last year's recommendations will be assessed. CSHCN is working closely with new local health

department staff providing an orientation to the itinerant clinic process.

The CSHCN Bureau continues its efforts to improve services to rural children with special health care needs through telehealth technology. These activities will supplement services to rural children with special needs using videoconference technology currently in place through the University of Utah Telehealth Network by providing long-distance clinical health care, community staffings, patient and professional health-related education and public health administration.

c. Plan for the Coming Year

Because rural Utah continues to have a shortage of pediatric subspecialists, the Bureau of CSHCN will continue to contract with the five local health departments to conduct itinerant clinics in nine sites across the state. In 2006, CSHCN will evaluate the need to continue or to consolidate clinic sites that only serve a small number of children. Additionally, CSHCN will explore the possibility of contracting with local pediatricians when possible. Through the contracts, local registered nurse care coordinators and clerical staff will schedule clinics, complete encounter forms, send out appointment letters, call families, provide care coordination services, arrange tests, collect reports and maintain medical charts. CSHCN will provide ongoing consultation and support on care coordination issues to contract staff. CSHCN will explore the possibility of electronic medical records for all clinics, which would greatly improve the access to records for rural clinics. Meanwhile, CSHCN will support the Access software database used by each site to schedule clinics and collect patient data. Information on resources and clinical processes will be provided.

CSHCN will work to integrate local rural clinic activities into the statewide Medical Home effort and will work closely with local primary care medical home providers to coordinate the care for children. Additionally, rural nurses will be encourage to collaborate with other CSHCN staff in rural Utah, including the staff from the Fostering Healthy Children Program and the Hearing, Speech and Vision Services Program. The chart audit process will be revised and a Quality Improvement process and will be initiated.

The CSHCN Bureau will continue its efforts to improve services to rural children with special health care needs through telehealth technology. These activities will supplement services to rural children with special needs using videoconference technology currently in place through the University of Utah Telehealth Network.

State Performance Measure 2: *The percent of cigarette smoking by teenagers in grades 9 through 12.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	14.9	11.9	11.9	7.3	7.3
Annual Indicator	11.9	8.3	8.3	7.3	7.3
Numerator					

Denominator					
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7.3	7.3	7.3	7.3	7.3

Notes - 2002

Data were obtained from the YRBS and are available for the state on a percentage basis. The source data for this measure has changed from a state survey to the YRBS and it should measure students in grades 9-12.

Notes - 2003

2003 YRBS data

Definition for "smoking": Percent of students in grades 9-12 who smoked cigarettes on one or more of the past 30 days. Data are collected every other year.

Notes - 2004

2003 YRBS data which is collected every other year in odd years

YRBS data are not available by numerator and denominator only percentage.
Definition for "smoking": Percent of students in grades 9-12 who smoked cigarettes on one or more of the past 30 days. Data are collected every other year.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 7.3% and the Annual Indicator was 7.3%.

Media campaign: Utah's The TRUTH anti-tobacco marketing campaign focus-group tested, developed and disseminated television and radio advertisements as well as print materials targeted to youth. The media messages focused on preventing the initiation of teen tobacco use and informing teen tobacco users about cessation services. To evaluate the effectiveness of the marketing campaign, the Tobacco Prevention and Control Program (TPCP) conducted a telephone survey with Utah teens in May and June of 2004. Survey results showed that anti-tobacco messages reached Utah's youth with 92% of survey participants reporting having seen anti-tobacco advertisements in the last month and 94% reporting that they knew the campaign slogan "The TRUTH". The TRUTH campaign continued to sponsor the annual "Truth from Youth" anti-tobacco advertising contest. Since its inception in 1997, more than 48,000 Utah students have created anti-tobacco ads for the contest. The winners of the contest had the opportunity to assist the media contractors in developing their concepts into public service announcements that were rotated into the formal anti-tobacco media campaign.

School policy projects: The TPCP funded schools in nine districts to develop comprehensive school tobacco policies, with 156 schools participating in revising their tobacco policies, developing plans for prevention and cessation curricula, institutionalizing staff training on tobacco issues, building school and community partnerships, and establishing a process to evaluate these efforts.

Youth tobacco cessation: Utah's local health departments and other TPCP community partners offered the Ending Nicotine Dependence (E.N.D.) program and the American Lung Association's Not on Tobacco (NOT) program to help teen smokers quit. More than 1,200 teens participated in cessation programs. Most of the teens who participated in E.N.D. were enrolled

in court-mandated classes following citations for tobacco possession. E.N.D. pre-and post-tests showed moderate quit and reduction rates for court-mandated E.N.D. classes. The TRUTH campaign continued to successfully inform teens about the availability of the Utah Teen Tobacco Quit Line, with 66% of Utah teens reporting that they were aware of the Quit Line (Utah Youth Media Survey, 2004).

Youth tobacco access: Utah law prohibits tobacco sales to minors under the age of 19. All 12 local health districts completed one to four retailer compliance checks in Utah's tobacco outlets. Results of all checks conducted per state fiscal year show a decline in non-compliance from 16% in SFY2001 to 8% in SFY2004. Compliance checks were supported by state and local initiatives to educate retailers about Utah tobacco laws and by efforts to recognize retailers who showed a continuous record of not selling tobacco to

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Target youth with “Truth About Tobacco” anti-tobacco media messages and conduct annual telephone surveys to evaluate the effectiveness of the media campaign			X	
2. Promote the implementation of the CDC Guidelines for School Health Programs to Prevent Tobacco Use and Addiction with Utah schools and school districts			X	
3. Promote teen smoking cessation through ongoing availability of school and community teen tobacco cessation programs in addition to the Teen Tobacco Quit Line			X	
4. Increase membership in Utah’s statewide youth movement against tobacco, the Phoenix Alliance			X	
5. Increase compliance with Utah laws that prohibit tobacco sales to minors by providing training and technical assistance to local agencies conducting compliance checks and retailer education programs				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

In the most recent statewide school tobacco survey, 7.3% of Utah students in grades 9 to 12 indicated that they had smoked cigarettes in the past 30 days (YRBS, 2003). Since most tobacco users become addicted to nicotine before the age of 20, preventing teen tobacco use continues to be a priority for the Division. The Tobacco Prevention and Control Program (TPCP) focuses on three major areas to reduce teen tobacco use: teen tobacco use prevention education (anti-tobacco counter-marketing campaign, prevention programs in schools and communities), teen tobacco cessation programs (school and community cessation programs, Teen Quit Line), and strengthening and enforcing tobacco-free policies and policies that limit youth access to tobacco.

Tobacco use prevention and education: The Utah anti-tobacco media campaign "The TRUTH" will target youth with research-based anti-tobacco television, radio and print ads and

community media events. The TPCP will conduct its annual telephone surveys of Utah youth to evaluate the effectiveness of the campaign. The program will expand funding and support for school districts and local health districts to implement CDC's "Guidelines for School Health Programs to Prevent Tobacco Use and Addiction".

Tobacco cessation: Support for teens who want to quit using tobacco continues to be available through school and community-based tobacco cessation programs and the statewide Teen Tobacco Quit Line. The TPCP supports Utah courts in meeting the legal requirement that teens cited for possession of tobacco complete a tobacco education program. The Teen Tobacco Quit Line and local cessation programs will be evaluated through pre-and post-tests and follow-up surveys.

Policies: Local health departments and other community partners will continue to assess and support passage of tobacco-free policies in locations that are frequented by youth. These locations include parks and other recreational venues, rodeos, sports fields, etc. Local health departments, in collaboration with law enforcement agencies, will complete an average of three compliance checks in all Utah tobacco retail outlets. The compliance checks will be supported by retailer education and recognition of retailers who continuously refuse to sell to minors.

c. Plan for the Coming Year

This SPM was dropped for FY06-FY10.

State Performance Measure 3: *The percent of bicycle helmet use among bicyclists 5-12 years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	16	16.5	16	20	21
Annual Indicator	15.1	14.6	20.1	20.2	24.5
Numerator	130	125	217	254	229
Denominator	861	857	1080	1260	933
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	25	26	26	27	27

Notes - 2003

Data were obtained through statewide observational studies conducted by our Violence and Injury Prevention Program.

Notes - 2004

Data were obtained through statewide observational studies conducted by our Violence and Injury Prevention Program.

a. Last Year's Accomplishments

This Performance Measure was achieved. The Annual Performance Objective was 21% and the Annual Indicator was 24.5%.

To increase the use of bike helmets among children in Utah, the Violence and Injury Prevention Program (VIPP) collaborated with partners to distribute over 7,000 bicycle helmets throughout the state during FY2004. The VIPP coordinated a statewide bike helmet safety campaign that included media interviews, PSAs, news articles, distribution of educational materials, and providing information on the UDOH website. Public education on bike helmets appeared in statewide newspapers, the Utah Safe Kids newsletter, local magazines, several TV news shows, and radio PSAs. VIPP assisted community partners to identify suppliers and sources for low cost helmets and obtain them for distribution through local programs.

The VIPP conducted its annual observation surveys to estimate bicycle helmet use in Utah. Among the sample of 933 elementary school-age bicyclists observed statewide, the helmet use rate was 24.5%, the highest rate in Utah. The results of the survey were shared with interested parties. A 10-year helmet use rate report, "Bicycle Helmet Use In Utah -- 10 Year Observational Survey 1994-2003" was written and is available to the general public through a downloadable PDF file from the UDOH website or as a hard copy. The report is an in-depth look at helmet use rates in Utah through a longitudinal study tracking use rates for age specific subgroups.

In May for National Bike Month, VIPP staff provided informational packets for schools and local health departments (LHDs) to explain the observance, provide bicycle safety rules and statistics, and offer examples of activities that could be conducted during the month. VIPP staff coordinated with the Utah Safe Kids Coalition during Safe Kids Week to promote the use of bicycle helmets. Many radio and TV spots aired promoting bicycle safety.

VIPP staff continued to provide training, technical support and funding for contracts through the MCH Block Grant with all LHDs to promote bicycle helmet use. In addition to media activities, LHDs conducted over 115 bicycle safety community activities reaching over 4,000 individuals. Examples of local community activities included distribution of helmets during bicycle skills courses and other promotional activities, low cost helmet sales, health fairs, bicycle safety camp, Easter bicycle helmet baskets, free ice cream coupons for those wearing a helmet, poster contests for kids, school assembly presentations, classroom instruction, local business sponsorship of bicycle skills courses, and bicycle helmet policies at elementary schools. Over 45,000 bicycle safety educational materials were distributed through PTAs and school mailings, bike helmet reminders in city water bills, and distributing bicycle safety brochures.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct annual observation survey to estimate bicycle helmet use in Utah.			X	
2. Conduct community education through the media, educational materials, articles for newspapers, and information on the UDOH Internet site			X	
3. Seek sources for low cost helmets to make available for distribution through health departments, schools, law enforcement, and other community partners		X		

4. Provide training, technical support, and funding for contracts with local health departments to promote bicycle helmet use		X		
5. Promote bicycle safety events, such as National Bike Month (May)			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

VIPP will continue to conduct its annual observation survey to estimate bicycle helmet use in Utah. The results of this survey will be shared with local health departments, media, law enforcement and other interested parties. Recommendations for improving helmet use will also be developed from a review of the results.

Community education continues through the media, distribution of educational materials, submission of articles to newsletters, provision of information on the UDOH Internet site, and at community events. The program continues to promote bicycle safety events, such as National Bike Month (May).

VIPP will continue to seek sources for low cost helmets and make them available for distribution through local health departments, schools, law enforcement and other community partners.

VIPP staff continues to provide training, technical support and funding for contracts with local health departments to promote bicycle helmet use. Examples of local community activities may include distribution of bike helmets during various events, low cost helmet sales, bike safety information for parents through PTAs and school, presentations in the community, poster contests for kids, school assemblies, and local business sponsorship of bicycle rodeos. Public education campaigns will also be conducted that use statewide and local media including newspaper articles, radio or TV PSAs and interviews, and letters to the editor.

c. Plan for the Coming Year

This SPM was dropped for FY06-FY10. However, VIPP will continue its work on promotion of bicycle helmet use in children.

State Performance Measure 4: *The percent of use of vehicle safety restraints among child occupants under eleven years of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	69	72	90	91	91
Annual Indicator	84.5	89.0	89.0	89.0	87.7

Numerator	3099	3547	3547	3547	4052
Denominator	3668	3985	3985	3985	4620
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	88	89	90	90	91

Notes - 2003

Data were obtained through statewide observational studies conducted by the Highway Safety Office, Department of Public Safety. This has not been implemented since 2001.

Notes - 2004

Data were obtained through the statewide Utah Safety Belt Observational Survey conducted by the Highway Safety Office, Department of Public Safety. summer 2004

a. Last Year's Accomplishments

This Performance Measure was not achieved. The Annual Performance Objective was 91% and the Annual Indicator was 87.7%.

The Violence and Injury Prevention Program (VIPP) collaborated with numerous partners to plan and implement strategies to increase child restraint use. Activities included: conducting car seat inspections; providing training on correct installation of child safety seats; providing low-cost car seats; conducting safety education for school age children; participating in safety fairs; working with the media; and, providing information on the UDOH website. Staff also responded to specific questions from the community on car seat checkpoint information, proper installation of car seats, Utah child passenger safety laws, importance of booster seats, and how long children need to be in a car seat. Some of these calls were in Spanish.

The VIPP provided funding, training, and technical support to local health departments in order to promote the correct use of child safety restraints, and to continue a coordinated statewide campaign to promote use of booster seats among children aged 4-8 years. Car seat checks and awareness classes were conducted throughout the state to provide training to parents about the proper use of booster seats. The program sponsored 100 car seat checkpoints and 367 other community activities reaching 33,169 individuals for promotion of child safety restraints. The program distributed 1,664 child safety seats and 73,871 others materials, such as brochures and flyers on child safety seats. In addition, there were 51 media activities such as PSAs, press conferences, and news releases conducted statewide. Booster seat use among 4-8 year olds increased statewide from 22.7% to 26.0%.

The VIPP is the lead agency for the Utah Safe Kids Coalition. Local coalitions and chapters facilitated motor vehicle safety events and distribution of child safety seats that were funded by various statewide partners. In Fall 2003, 60,000 English and 8,000 Spanish Safe Kids newsletters were printed and provided to hospitals, daycare centers, schools, pediatricians, etc. The newsletter was also available on several websites. Other partners assisted in funding the newsletter. The spring 2004 newsletter was not published because support from the major partner who has conducted the layout and printing for many years was lost.

Staff helped coordinate the Child Passenger Safety Training Road Show where hospitals and clinics in over 15 communities were visited teaching pediatricians, doctors, nurses, and physical therapists about child passenger safety. Staff helped plan the Transporting Children with Special Health Care Needs Conference that was designed to teach child passenger safety

options for children with special health care needs.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Conduct statewide booster seat campaign, including education of children and parents, conducting free car seat/booster seat inspections and conducting observation surveys to estimate booster seat use in local communities			X	
2. Promote child protection through education and media activities, free car and booster seat inspections, making low cost car and booster seats available to low-income families; and providing information about child passenger safety on VIPP web site			X	
3. Conduct 4-day certification training sessions in local communities to increase the number of Certified Child Passenger Safety Technicians throughout the state				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Violence and Injury Prevention Program (VIPP) continues to collaborate with state and local agencies and other community partners to plan and implement strategies to increase child restraint use. Partners include local health departments, the Utah SAFE KIDS Coalition and local SAFE KIDS coalitions and chapters, the Utah Department of Public Safety/Highway Safety Office, the Utah Safety Council, Primary Children's Medical Center and others.

Education and prevention efforts continue through activities such as: car seat and booster seat inspections; assisting with 4-day certification training sessions in local communities to increase the number of Certified Child Passenger Safety Technicians throughout the state; facilitating the purchase and distribution of low-cost car seats and booster seats; conducting safety education for school age children; conducting media PSAs and interviews; providing articles for newspapers and newsletters; responding to requests for information by the public, professionals, legislators and others; supporting car seat fitting stations throughout the state, including the Permanent Car Seat Fitting Station at Primary Children's Medical Center; and, providing information on the UDOH Internet website.

The Utah SAFE KIDS Coalition will publish over 100,000 newsletters that will be distributed to parents with injury prevention tips and resources. SAFE KIDS will provide grants (through the National SAFE KIDS Campaign) to local SAFE KIDS Chapters to support them in community educational events. The Utah SAFE KIDS Coalition coordinator attends some of these events as a Certified Child Passenger Safety Senior Checker.

VIPP continues to provide funding, training and technical support to local health departments to support a coordinated statewide campaign to promote use of child safety seats and booster

seats. The campaign will include local public awareness and education activities in targeted communities, as well as free car seat/booster seat checkpoints in the targeted communities. Evaluation of this campaign will be based primarily on booster seat observation surveys conducted twice yearly in the target communities. In addition to these surveys, VIPP will obtain data from Utah Highway Safety Office seat belt surveys and make the data available to local health departments and other interested parties. These statewide data will be the basis for tracking progress toward state objectives for child occupant protection.

c. Plan for the Coming Year

This SPM was dropped for FY06-FY10.

State Performance Measure 5: *Percent of children in kindergarten through twelfth grade who receive two doses of Measles, Mumps, and Rubella (MMR) vaccine.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	96	96	96	96	96
Annual Indicator	97.8	98.1	97.9	97.6	97.6
Numerator	469538	476571	478744	492499	492499
Denominator	479925	485905	489001	504536	504536
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	97	97	97	97	97

Notes - 2003

The data were obtained from the Immunization Program, UDOH as part of the school entry database.

Notes - 2004

The data were obtained from the Immunization Program, UDOH as part of the school entry database.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 96% and the Annual Indicator was 97.6%.

During FY04, the Immunization Program continued to educate parents, school administrators, and providers about this state requirement and work with school districts and school nurses to enforce the requirement. The electronic database supported efficient annual and end-of-year reports in collaboration with the State Office of Education. The Immunization Program

continued its strong collaborative relationship with the State Office of Education in collection and analysis of school immunization data to increase rates and develop strategies to increase compliance. Educational materials including "The Utah School Law -A Parent's Guide" were distributed to schools, local health departments, and community and migrant health centers. The Immunization Program continued to promote up-to-date immunizations in its activities with various agencies, such as local health departments, community health centers, and continued to promote the medical home concept for children with local health departments to enable parents to obtain needed child health services by one provider in one location.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with the State Office of Education to promote, implement, and enforce the school rule requiring all Kindergarten-12th grade students be immunized with two doses of MMR vaccine				X
2. Collect information from schools on the number of K-12 students receiving 2nd dose MMR			X	
3. Enhance the electronic database developed for reporting to include end-of- year reports in collaboration with the State Office of Education				X
4. Continue strong collaborative relationship with the State Office of Education in collecting and analysis of school immunization data to increase rates and develop strategies to increase compliance with immunization requirements for school attendance			X	
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY05, the Immunization Program continues to educate parents, school administrators, and providers about this state requirement and works with school districts and school nurses to enforce the requirement. The electronic database supports annual and end-of-year reports in collaboration with the State Office of Education. The Immunization Program continues its strong collaborative relationship with the State Office of Education in collection and analysis of school immunization data to increase rates and develop strategies to increase compliance with state laws. Educational materials including "The Utah School Law -A Parent's Guide" are distributed to schools, school nurses, local health departments, and community and migrant health centers. The Immunization Program continues to promote up-to-date immunizations in its activities with various agencies, such as local health departments, community health centers, and continues to promote the medical home concept for children with local health departments to enable parents to obtain needed child health services by one provider in one location.

c. Plan for the Coming Year

This SPM was dropped for FY06-FY10.

State Performance Measure 6: *The rate (per 10,000) of neural tube birth defects.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	5	6.0	6.0	6.3	6.3
Annual Indicator	6.5	8.1	6.9	5.2	5.2
Numerator	31	39	34	26	26
Denominator	47578	48145	49418	50076	50076
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	6	6	6	6	6

Notes - 2003

The data are from the Utah Birth Defect Network and is tracking anencephaly, craniorachischisis, meningomyelocele and encephalocele. The ICD-9 are 740.0,740.1,741.0-741.9, and 742.0.

Notes - 2004

The data are from the Utah Birth Defect Network and is tracking anencephaly, craniorachischisis, meningomyelocele and encephalocele. The ICD-9 are 740.0,740.1,741.0-741.9, and 742.0.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 6.2/10,000 births and the Annual Indicator was 5.2/10,000 births.

During FY04, the Utah Birth Defect Network (UBDN) successfully continued to monitor the occurrence of all major structural malformation in the state.

Based on the UBDN data, WIC clients continue to fit the profile of women having a child born with an NTD. The UBDN was again, successful in securing external funding to purchase additional multivitamins with folic acid for WIC clients. The purpose of the WIC vitamin project is to provide face to face education to non-pregnant WIC clients about consuming multivitamins with folic acid, providing free multivitamins, and evaluating the effectiveness of this intervention activity. The annual WIC survey demonstrated that those women participating in the WIC vitamin project, 88% took their multivitamins.

The BRFSS statewide telephone survey results for 2003 showed that 47.6% of women, ages 18-44, consumed folic acid daily. Despite statewide folic acid education, over 50% of women in Utah do not currently take a multivitamin with folic acid.

Women who have a child with an NTD have a 3% chance of having another child born with an NTD. Therefore, it is imperative that these women receive the information about the increased

folic acid soon after their first child is born with an NTD. During this fiscal year, the UBDN provided an NTD Recurrence Prevention Packet to every woman who delivered a fetus/infant with an NTD that did not see either a genetic counselor or perinatologist at one of the four perinatology centers.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor all major structural birth defects in Utah			X	
2. Monitor the prevalence of NTDs in Utah			X	
3. Monitor prevalence of other major structural birth defects in Utah			X	
4. Administer BRFSS household survey to women of childbearing years for folic acid awareness trend data			X	
5. Educate consumers and health care providers about folic acid and birth defect prevention			X	
6. Distribute NTD recurrence packet after having a pregnancy affected by an NTD		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Utah Birth Defect Network (UBDN) will continue to monitor the occurrence of all structural major malformations for all pregnancy outcomes occurring in women who are Utah residents at time of delivery. Specifically, neural tube defects (NTDs) will be monitored closely since these congenital malformations are responsive to public health intervention with folic acid.

An annual survey to WIC participants will be administered in the late spring or early summer of 2004 which will include several questions to assess whether women received free multivitamins (through a March of Dimes grant) and determine if they consumed these vitamins and if not, the reasons why. This information will be shared with the Utah Folic Acid Council to determine if other activities will be needed to promote folic acid intake. The Utah Folic Acid Council, a multi-agency organization, will continue to meet quarterly to assess data and appropriate activities to best reach consumers and health care providers in Utah to increase awareness, knowledge and consumption of folic acid for the prevention of birth defects. If funding permits, the multivitamin project with WIC will be continued.

As funding permits, the UBDN will pay for the BRFSS statewide telephone survey to query women in their childbearing years, 18-44, to assess awareness, knowledge and consumption of folic acid.

The UBDN will publish its 2nd newsletter July 2004 that will include information about NTDs and folic acid. This newsletter will be sent to health care providers in Utah, hospital administrators, and community agencies.

The NTD Recurrence Prevention packet will be provided to families that have not seen the Pediatric Nurse Practitioner at the Spina Bifida Clinic (Primary Children's Medical Center), a genetic counselor at one of the perinatology centers or a perinatologist. These packets will

contain recurrence prevention materials, resources for families and parent support groups, in both English and Spanish.

Activities for Birth Defects Prevention Month in January 2005 will be planned. The 5 banners will be located in high traffic areas around the valley, news releases will be sent to newspapers and radio stations statewide and agencies will be asked to place material in their employees' check payments.

c. Plan for the Coming Year

This SPM was dropped for FY06-FY10.

State Performance Measure 9: *The percent of pregnant women with adequate weight gain who deliver live born infants.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	71	69.5	69.8	67.5	84
Annual Indicator	65.2	65.8	83.5	81.4	81.4
Numerator	30842	31510	39626	40561	40561
Denominator	47331	47915	47429	49834	49834
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	81.5	81.6	81.7	81.8	81.9

Notes - 2003

Office of Vital Records and Statistics. UDOH 2002
Annual Indicators for 1999 through 2001 have been revised. The SAS code written to calculate this Indicator had to be corrected.

Notes - 2004

Office of Vital Records and Statistics. UDOH 2003

a. Last Year's Accomplishments

The performance measure was not achieved. The Performance Objective was 84% and the Annual Indicator was 81.4%.
Adequate weight gain among pregnant women consist of two weight groups: women achieving adequate weight gain and women categorized as gaining excessive weight. The totals of these two categories resulted in an increase in adequate weight gain among Utah women experiencing a live birth from 1999 to 2003. Over 5 year period the percent of women experiencing adequate weight gain rose from 82.1% in 1999 to 84.2% in 2003. Over the same

5 years, the number of women with inadequate weight gain declined from 17.9% to 15.7%.

Closer analysis reveals that while the adequate plus the excessive weight gain category has shown an increase, that increase may be driven by increases in the percentage of women with excessive weight gain. From 1999 through 2003, the percentage of women categorized as having achieved adequate weight gain during pregnancy decreased from 37% to 35.9%. During the same time period, the number of women with excessive weight gain increased from 45.1% to 48.3%. Due to the upward trend in the percentage of women experiencing excessive weight gain, strategies may need to be developed and implemented impacting these women.

The CDC 2003 Pregnancy Nutrition Surveillance Report for Utah WIC participants was reviewed. It indicates that from 1999 through 2003 the percentage of women with ideal weight gain during pregnancy trended upward from 33.6% to 34.5%. Lower percentages of attainment of ideal weight gain in pregnancy were noted among Black, American Indian/Alaskan Native and Asian/Pacific Islander women. Utah WIC participants compare favorably with WIC participants nationally with 34.5% of Utah WIC participants achieving their ideal weight gain compared to 29.6% of WIC participants nationally.

A link was added to the Reproductive Health Program's website to assist women in locating nutritionists in their area for consultation. In December 2003, a PRAMS newsletter on prenatal education was distributed to private prenatal care providers and those at community health centers, hospitals, insurance companies and managed care organizations. Information on prenatal education was obtained from 1999 PRAMS surveys which queried women on whether their prenatal care provider talked with them about what they should eat during pregnancy and how much weight they should gain. Results indicated that 75% of women were counseled regarding nutrition in pregnancy and 82% were counseled about weight gain.

Managed Care Organizations (MCO) contracted with Medicaid for prenatal services cover referral of women with nutritional risks to dieticians. These referrals are not captured in required HEDIS data sets and the MCOs' billing mechanisms do not break out nutritional services. As a result, it is not possible to determine the number of women receiving those services.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Monitor data regarding weight gain in pregnancy from birth certificate data, WIC data and the Pregnancy Risk Assessment and Monitoring System (PRAMS) data			X	
2. Add information on nutrition and weight gain in pregnancy to the Reproductive Health Program’s website			X	
3. Promote nutrition education and appropriate referral of women at high nutritional risk for counseling among HMOs contracted with Medicaid			X	
4. Distribute PRAMS report on patient education during pregnancy including nutrition to prenatal care providers in Utah			X	
5.				
6.				
7.				
8.				
9.				

10.

b. Current Activities

During FY2005 adequacy of weight gain during pregnancy will be promoted through collaboration between the WIC and Reproductive Health Programs to support WIC's ongoing statewide goal of increasing the percent of pregnant women achieving ideal weight gain during their pregnancies by 1%. Activities will include promotion and assistance in distribution of weight goal and health behavior change cards to pregnant women participating in WIC, the Presumptive Eligibility Program, March of Dimes Teddy Bear Den and to MCOs for distribution to their pregnant clients. Possible development of a brief video emphasizing healthy nutrition during pregnancy will be discussed and use of a Baby Your Baby 4th Friday segment on KUTV to promote appropriate weight gain during pregnancy will be brought before the Baby Your Baby Advisory Committee for possible development. As appropriate, monitoring of Medicaid contracted MCOs for documentation of weight gain during pregnancy and referral of women at high nutritional risk for individual nutritional counseling will be encouraged. Adequacy of weight gain during pregnancy will be monitored through review of relevant databases: vital records, PRAMS, and WIC's CDC Pregnancy Nutrition Surveillance Reports.

c. Plan for the Coming Year

This SPM was dropped for FY06-FY10.

State Performance Measure 10: *The percent of women delivering live born infants reporting cigarette smoking during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	7.6	7.9	7.8	7.7	7.6
Annual Indicator	8.1	7.5	7.0	6.4	6.4
Numerator	3828	3612	3455	3206	3206
Denominator	47331	47915	49140	49834	49834
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	7	6.7	6.4	6.1	5.8

Notes - 2002

This is a new measure for the FY2002 application.

Notes - 2003

Office of Vital Records and Statistics. UDOH 2002

Notes - 2004

Office of Vital Records and Statistics. UDOH 2003

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 7.6% and the Annual Indicator was 6.4%.
Utah Vital Records data indicated that 6.4% of women delivering live born infants in 2003 reported tobacco use during pregnancy, a decrease of 0.6% from 2002. Although this rate is low compared to many other states, the well documented impact of tobacco use during pregnancy on low birth weight and other poor pregnancy outcomes necessitates that the state continue to work towards further preventive efforts as well as efforts to prevent relapse once cessation has been achieved.

The Reproductive Health Program (RHP) and the Tobacco Prevention and Control Program (TPCP) implemented public education regarding the importance of smoking cessation during pregnancy via health fairs, the RHP web site and media opportunities.

The RHP distributed smoking cessation materials translated into Spanish to local health departments, at health fairs around the state and on the RHP website. The RHP continued to work with Medicaid to certify smoking cessation intervention programs for pregnant Medicaid recipients. The TPCP implemented a marketing campaign about smoking during pregnancy on radio and TV. The Program distributed posters on smoking during pregnancy, as well as collateral items such as quit cards, a self-help guide, hats, and t-shirts for babies.

TPCP partnered with WIC, Medicaid, Teen Mother and Child Program at the University of Utah, and local health departments. Services for pregnant women were available through the Utah Tobacco Quit Line. The TPCP and Medicaid collaborated to provide nicotine replacement therapies or Zyban to pregnant women when prescribed by their health care provider.

The WIC Program queries all women enrolled in the program about smoking status. Women who are identified as smokers receive counseling and are also referred to smoking cessation programs. WIC also collaborated with TPCP to develop short scripts based on the Public Health Service Clinical Practice Guidelines for local clinic staff to use when giving advice on quitting to pregnant women. At selected clinics, WIC staff followed up with women who reported smoking at 2 weeks, 3 months, and 6 months after the first intervention to track their progress and offer additional encouragement. Some WIC clinics chose to display tobacco prevention and cessation media-related items in their clinics.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Work with Medicaid to certify smoking cessation interventions for pregnant Medicaid recipients		X		
2. Distribute new smoking cessation materials in English and Spanish to the public and healthcare providers through the local health departments and health fairs			X	
3. Include smoking cessation information on RHP website			X	
4.				
5.				
6.				
7.				

8.				
9.				
10.				

b. Current Activities

The Reproductive Health Program (RHP) and the Tobacco Prevention and Control Program (TPCP) will implement public education regarding the importance of smoking cessation during pregnancy via health fairs, the Reproductive Health Program web site and media opportunities that arise.

The RHP continues working with the Division of Health Care Financing to certify smoking cessation interventions for pregnant Medicaid recipients.

TPCP is working with local health departments to implement the "First Step -- A Pregnant Woman's Guide to Quitting Tobacco Use" program and other tobacco cessation help for pregnant women.

In FY05, the TPCP will investigate opportunities to build partnerships with existing media campaigns (i.e. Baby Your Baby) that target pregnant women.

c. Plan for the Coming Year

This SPM was dropped for FY06-FY10.

State Performance Measure 11: *The proportion of pregnancies that are intended.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2000**	**2001**	**2002**	**2003**	**2004**
Annual Performance Objective	66.9	67.4	67.9	66	66
Annual Indicator	66.3	68.4	65.5	66.4	66.4
Numerator	31380	32760	32197	33099	33099
Denominator	47331	47915	49140	49834	49834
Is the Data Provisional or Final?				Final	Provisional
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	66.4	66.5	66.6	66.7	66.8

Notes - 2003

PRAMS data projected from 2001

Notes - 2004

PRAMS data projected from 2002

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 66% and the Annual Indicator was 66.4%.

Utah PRAMS survey data are used to measure this Performance Measure. Although the annual indicator of 65.5% does not meet the objective of 66%, since the standard error is 0.8% we could consider that the objective was met.

The Reproductive Health Program (RHP) distributed family planning and preconceptional brochures to WIC clinics, community health centers, local health departments, at health fairs and other locations frequented by reproductive aged women. RHP also distributed information on unintended pregnancy, family planning and the importance of adequate inter-pregnancy spacing via Web pages, poster sessions, and displays at health fairs. RHP nurse consultant educated local health department staff and others on the availability of emergency contraception for their clients.

RHP continued to collaborate with Medicaid to promote awareness of the state's Primary Care Network, which includes family planning services.

The RHP, in conjunction with the Wasatch Homeless Health Care Program in Salt Lake City, had hoped to implement a family planning program for women at high risk for unintended pregnancy, homeless women, women recently incarcerated, or women in substance abuse treatment programs. Wasatch Homeless Health Care did not choose to participate due to inadequate staffing. Project Reality, a treatment center for drug-using women, was approached to participate instead. When the women receiving services at Project Reality were surveyed as to their needs, family planning was ranked lowest on their list of needs; therefore it was decided to discontinue this project.

The Phase V PRAMS survey was developed during this time period with input from the PRAMS Advisory Committee. It was decided that the Utah PRAMS Survey could be revised to gather more information about pregnancy intention and family planning methods. Questions were added to the new survey to include time to pregnancy intention if the pregnancy was mistimed. Another question addresses family planning methods being used at conception. This question will allow us to look at contraceptive failure rates.

Staff from the MCH Bureau collaborated with Health Care Financing (HCF) staff to develop an 1115 waiver for family planning services for women on prenatal Medicaid for up to two years postpartum. The funding for these services would be off-set by the cost savings of prevented unintended pregnancies, including prenatal care and well child care services. Currently, women on prenatal Medicaid lose their coverage two months postpartum and thus have no long-term coverage for family planning services.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Distribute information on family planning services in Utah			X	
2. Distribute information on unintended pregnancy and interpregnancy intervals on RHP web site, poster sessions, and other marketing strategies			X	
3. Work with Medicaid to promote awareness of the state Primary Care				

Network among local health departments and clinics			X	
4. Collaborate with Weber-Morgan Health District to deliver appropriate family planning materials to jail inmates			X	
5. Implement family planning program for high-risk women in Salt Lake County			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During 2001, Utah Pregnancy Risk Assessment Monitoring System (PRAMS) data reported that 34.5% of pregnancies were unintended, an increase of 2.9% from 2000. Reduction of unintentional pregnancy (pregnancies that are mistimed (unplanned, but desired) and unwanted (unplanned and not desired) is a critical issue as unintentional pregnancy has been linked to many poor pregnancy outcomes.

The Reproductive Health Program (RHP) plans to distribute family planning and preconceptional brochures to WIC clinics, community health centers, local health departments, at health fairs and other locations frequented by reproductive aged women; as well as, distribute information on unintended pregnancy, family planning and the importance of adequate inter-pregnancy spacing via Web pages, poster sessions, and other social marketing strategies. The family planning nurse consultant for the RHP will continue to educate local health department staff and other MCH Title V grantees on the availability of emergency contraception for their clients.

The RHP will continue to collaborate with the Division of Health Care Financing to promote awareness of the state's primary care waiver, which includes a family planning component.

The RHP will continue to work on identifying ways to procure low cost contraception for the State's local health departments.

c. Plan for the Coming Year

The RHP plans to distribute family planning and preconceptional brochures to WIC clinics, Community Health Centers, Local Health Departments, at health fairs and other locations frequented by reproductive aged women; as well as, distribute information on unintended pregnancy, family planning and the importance of adequate inter-pregnancy spacing via Web pages, poster sessions, and other social marketing strategies. The family planning nurse consultant for the RHP will educate local health department and other MCH Title V grantees on the availability of emergency contraception for their clients.

The RHP will collaborate with the Division of Health Care Finance to promote awareness of the state's primary care waiver, which includes a family planning component.

The RHP will work on identifying ways to procure low cost contraception for the State's local health departments.

The RHP will collaborate with Health Care Finance (HCF) staff to develop an 1115 waiver for family planning services. The waiver proposes to cover family planning services for women on prenatal Medicaid for up to two years postpartum. The money to fund the waiver would come from the cost savings of prevented unintended pregnancies, including prenatal care and well

child care services.

Currently, women on prenatal Medicaid lose their coverage two months postpartum.

Upon receipt of the 2004 PRAMS dataset, the RHP will evaluate women's pregnancy intention, use of contraceptive methods, and which methods appear to have higher failure rates among Utah women. The RHP can then use this information to design educational messages about specific contraceptive methods and correct use.

The RHP will educate women about fertility cycles and correct contraception use by developing educational messages and disseminating them through the RHP website, at health fairs, and other locations.

State Performance Measure 12: *Percent of children six through nine years of age enrolled in Medicaid receiving a dental visit in the past year*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2000	2001	2002	2003	2004
Annual Performance Objective	43.5	44	43	44	45
Annual Indicator	43.5	42.7	46.2	45.2	47.2
Numerator	8869	7860	10216	11231	12772
Denominator	20367	18414	22134	24863	27088
Is the Data Provisional or Final?				Final	Final
	2005	**2006**	**2007**	**2008**	**2009**
Annual Performance Objective	48	48	49	49	50

Notes - 2003

The data are from Medicaid CMS 416 for FFY03

Notes - 2004

The data are from Medicaid CMS 416 for FFY04.

a. Last Year's Accomplishments

The performance measure was achieved. The Performance Objective was 45% and the Annual Indicator was 47%.

During FY04, the Oral Health Program (OHP) collaborated with the Utah Oral Health Coalition Steering Committee in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits. Efforts to update oral health education materials/curricula used in elementary schools have continued. The OHP collaborated with staff in the UDOH Division of Health Care Financing to expand current CHEC

outreach programs. Through these expanded efforts, outreach workers have provided a higher level of case management for children needing dental services. The OHP continued to work closely with the Utah Dental Association Access Committee and the Utah Oral Health Coalition Steering Committee in efforts to increase the number of dentists willing to see Medicaid participants in order to increase access to oral health care. The CHEC dental case management system pilot, which had been implemented in three local health departments, was expanded into several more health departments. CHEC outreach staff are responsible for: 1) conducting outreach to encourage use of preventive and follow-up services; 2) educating parents about CHEC benefits and the importance of keeping appointments for their children; 3) working with parents to help reduce barriers to accessing care such as transportation, childcare, language, etc.; 4) serving as liaisons with dental offices to recruit and encourage dentists to become Medicaid providers and see Medicaid children. In addition, Division of Health Care Financing staff has worked with dental office staff on billing and other issues that have arisen.

Figure 4b, State Performance Measures from the Annual Report Year Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Educate the medical and dental provider community in an awareness campaign emphasizing the benefits of early and regular dental visits			X	
2. Collaborate with Medicaid in expansion of the Dental Case Management Projects				X
3. Advocate and promote early childhood caries prevention and intervention programs			X	
4. Promote increased dentist participation in the Medicaid program				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

During FY05, the Oral Health Program (OHP) continues to collaborate with the Utah Oral Health Coalition in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits. Efforts to update oral health education materials/curricula used in elementary schools continue. The OHP will continue to collaborate with staff in the UDOH Division of Health Care Financing to expand current CHEC (Utah's EPSDT) outreach programs. Through these expanded efforts, outreach workers provide a higher level of case management for children needing dental services. The OHP continues to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid participants in order to increase access to oral health care. The CHEC dental case management system, which has been implemented in some local health departments, is planned to be expanded into several more local health departments. CHEC outreach staff are responsible for: 1) conducting outreach to encourage use of preventive and follow-up services; 2) educating parents about CHEC benefits and the importance of keeping appointments for their children; 3) working with parents to help reduce barriers to accessing care such as transportation, child care, language, etc.; and, 4) serving as liaisons with dental offices to recruit and encourage dentists to become

Medicaid providers and see Medicaid children. In addition, Division of Health Care Financing staff will continue to work with private dental office staff on billing and other issues that may arise.

c. Plan for the Coming Year

During FY06, the Oral Health Program (OHP) will collaborate with the Utah Oral Health Coalition in the development and implementation of a public awareness campaign emphasizing the benefits of early and regular dental visits. Efforts to update oral health education materials/curriculum, which are used in elementary schools will continue. The OHP will collaborate with staff in the UDOH Division of Health Care Financing to expand current CHEC outreach programs. Through these expanded efforts, outreach workers will provide a higher level of care coordination for children needing dental services. The CHEC dental case management system, which has been implemented in some local health departments is planned to be expanded into several more health departments. CHEC outreach staff will be responsible for: 1) conducting outreach to encourage use of preventive and follow-up services; 2) educating parents about CHEC benefits and the importance of keeping appointments for their children; 3) working with parents to help reduce barriers to accessing care such as transportation, child care, language, etc.; and, 4) serving as liaisons with dental offices to recruit and encourage dentists to become Medicaid providers and see Medicaid children.

In addition, Division of Health Care Financing staff will work with private dental office staff on billing and other issues that may arise. The OHP will also continue to work closely with the Utah Dental Association and the Utah Oral Health Coalition in efforts to increase the number of dentists willing to see Medicaid patients in order to increase utilization of oral health care services.

E. OTHER PROGRAM ACTIVITIES

The State Title V agency is involved in many activities that address the needs of mothers and children in the state. The Division of Community and Family Health Services has established several new programs within the past five years that impact others and children. These include Asthma and Chronic Disease Genomics Programs. Both of these programs will be important to the public health work focused on mothers and children in the state.

The Asthma Program is designed to develop state capacity to address asthma. The Program monitors asthma rates and is concerned about the rise in children reported to have asthma, which in 2004 was 8%, an increase since 2001 with 5% reporting asthma. The Program works with schools to address the health needs of children with asthma. Legislation was passed in 2004 that allows children with asthma to carry inhalers with them in school to use as needed. The change was needed due to state rule that prohibits children from carrying any kind of drug on school property. The Program has developed a school manual that assists school personnel in understanding asthma better and how they can assist a child with asthma at school. The manual can be accessed at http://health.utah.gov/asthma/schools.html

The Chronic Disease Genomics Program promotes awareness of genomics and how genes can impact the health of the public. The Program provides up-to-date resources on genomics in today's world and information on the importance of family health history in understanding one's own health. http://health.utah.gov/genomics/index.html This program and its work will become even more important as we learn more about genomics and its relationship to health.

In addition, other programs in the Department, such as HIV/AIDS, Heart Disease and Stroke Prevention, and Diabetes Prevention and Control, include Title V staff in their work. Of particular note is the Gold Medal School program. The Gold Medal School (GMS) program makes it possible to

provide opportunities for physical activity and healthy nutrition choices in elementary schools at a time when budget cuts and testing requirements overshadow physical activity and nutrition. The Utah Department of Health developed the GMS program in 2001 using the State Office of Education's core curriculum and the Centers for Disease Control's guidelines to address overweight and obesity in elementary schools. Today, it is the most successful program for physical activity and nutrition in the state, reaching 75,741 kids in 160 schools! Schools that sign up for GMS are required to meet certain criteria, such as developing policy that implements the State Office of Education's physical activity core curriculum that includes 90 minutes of structured physical activity each week, or establishing a Gold Medal Mile walking program in which each student's goal is to walk a mile each week, setting policy that food is not used by teachers as a reward or punishment, etc. A University student majoring in health nutrition, physical education, or elementary education is assigned to each participating school. Criteria are set for bronze level, silver level and gold level with schools receiving a cash prize that they can use for new PE equipment, nutrition resources or tobacco prevention materials.

The Center for Multicultural Health, created by 2004 Legislation, is working with programs to discuss program needs in outreach to members of different cultures in the state as well as provide appropriate data on subpopulations. The Division houses the Center, which benefits Division programs due to close proximity. The Center Coordinator has interfaced with programs to assess their needs and will be working with them to develop strategies that will increase agency capacity for cultural competence. The Department recently released a report on the Health Status by race and ethnicity, which provides a wealth of information on each subpopulation in the state. The report can be accessed at http://health.utah.gov/opha/publications/raceeth05/RaceEth05.htm

In 2001, Legislation was passed to allow a mother not wanting to keep her newborn baby to drop the baby off at a hospital with no questions asked. The Legislation was crafted to help reduce the possibility of infant death due to a mother "discarding" her baby in a dumpster or other places leading to the infant's death. The Adolescent Health Coordinator is working with the sponsor of the bill and representatives of various agencies to develop print materials and resources for the public to promote the "safe haven" option for women who chose not to keep their babies. The campaign will kick off in September 2005. The Department will pay for access to a national toll-free 24/7 hotline for anyone in Utah to avail themselves of this service.

The Division participates on numerous advisory committees sponsored by other state agencies or private agencies to enable the Title V programs collaborate with vital external partners in their work. Examples include the Child Abuse Prevention Council, Child Care licensing, and so on. In general the state title V agency has exerted concerted effort to increase its collaborative efforts with private providers, professional associations and its agency partners to address the health needs of mothers and children, including those with special health care needs.

As we have developed data capacity, we have expanded our ability to "research" various issues impacting mothers and children in the state. For example, the MCH Staff has looked at weight prior to pregnancy and weight gain in pregnancy to determine its possible impact on pregnancy outcomes; postpartum depression and how women are not screened or listened to when they express concerns about their mental health; prenatal care analysis to determine factors associated with late entry, and so on. Expansion of data capacity has enabled programs to conduct surveys, compile data that are important in identifying a health issue and related factors.

F. TECHNICAL ASSISTANCE

Utah's Title V Technical Assistance Needs include:
1) Uninsured women - An area that we feel particular concern is the proportion of women of childbearing age who are not insured. We have focused a great deal of our statewide efforts on children and while we have a ways to go to improve in this area, we need to acknowledge that women have higher rates of no insurance than the general population. We would like technical assistance on methods to address this problem. When women have no insurance, they are less likely to plan pregnancy, engage in preventive health care, such as family planning or prenatal care. The most

common reason women reported late entry into prenatal care was "no money". If we could ensure that more women had insurance, we would see improvement in intended pregnancy, early prenatal care, etc.

2) Early Childhood Systems Development is an area in which we are struggling. The SECCS grant supports the State Title V agency's efforts to develop a coordinated system of care for young children and their families. However, we have been faced with numerous challenges in this endeavor. The state has had an early childhood committee for a number of years that has functioned on a sporadic basis. For a period of time, the Head Start State Collaboration Office worked with a committee focused on young children while at the same time the Department of Health had convened a group of agency representatives to attempt to integrate services. In 2003, the two groups merged into one, called the Early Childhood Council. Previous to the merge, the state had sponsored an early childhood Summit in 2002 that was designed to bring policy makers together with agency staff, parents, program staff, etc. to discuss how the system of services could be integrated. However, the "system" concept was missing a couple of vital components, namely health and family support. The planning group continued working on the materials developed from the Summit to develop "A Blueprint for Action". This document now serves as the basis for the work of the Early Childhood Council (ECC). Challenges include: 1) how to define a "system" of services for young children and their families, 2) how to promote the broader scope of early childhood services to be inclusive of all services needed by young children and their families to succeed, 3) how to better utilize the resources involved in this effort. We would request technical assistance in supporting our efforts.

3) Mental Health among mothers and children in the state -- A significant portion of Utah mothers who deliver a live born infant report feeling moderate to severe depression several months after delivery. Mental health for children and youth in the state is an issue that concerns many working in the field of mental health and substance abuse, as well as those of us in public health. We would request technical assistance to help us determine best practices to promote mental health among families in the state. The state Title V agency is not interested in treatment and therapy, but rather, screening and early recognition of social emotional issues in young children, their mothers (and fathers), and among children of all ages. We are particularly concerned about the early childhood population of children since social emotional problems in the children or their parents may negatively impact their development. We are interested in best practices for children and mothers in this area that we might be able to replicate in Utah.

4) Overweight and Obesity -- Given the national trend in overweight and obesity, Utah public health officials are very concerned about the increasing trend in the state. We want to focus our efforts on women of childbearing ages in terms of prepregnancy weight and weight gain during pregnancy. Prepregnancy weight can be considered a proxy for the weight of all women in these ages and we need to work to ensure that as women prepare for pregnancy they consider their weight along with other possible risk factors, such as medications, chronic health conditions, etc. As women go on to have pregnancies, we want to ensure that they don't continue to keep on unnecessary weight after the pregnancy, compounded by additional pounds with each pregnancy. We would like technical assistance on promotion of healthy weight among women of childbearing ages.

In addition we would like technical assistance on best practices related to healthy weight in children of all ages. We have the Gold Medal School program, which promotes healthy lifestyles, including good nutrition and adequate physical activity in elementary schools. We want to expand the program into secondary schools, which would cover all school-aged children and youth in the state. Best practices on how to reach youth on the issues of healthy food and physical activity would be very helpful as we strategize to attack this problem among Utah children.

5) Transition for CYSHCN - we would like assistance with transition issues for CYSHCN.

6) Cultural Competency - since one of our priorities is ethnic and cultural issues, we would like TA from the National Center for Cultural Competency so that we can better address issues for ethnic and

minority populations in our state

V. BUDGET NARRATIVE

A. EXPENDITURES

Please see notes related to Form 3 and Form 4.

B. BUDGET

The Division of Community and Family Health Services (CFHS) is organized to address specific maternal and child health needs through a partnership between State agencies and the private sector to form a coordinated statewide system of health care. CFHSs Block Grant funds are distributed according to the plan of expenditures contained in this application which is based upon a statewide assessment of the health of mothers and children in Utah. Funding reported within this application/annual report is based on the state fiscal year.

The amount of state funds that will be used to support Maternal and Child Health programs in FY06 is shown in the budget documentation of the state application. We assure that the FY89 maintenance of effort level of State funding at a minimum will be maintained in FY06 [sec.505(a)(4)].

For each four federal dollars a minimum of three state dollars is specifically designated as match. CFHS allocates a total of $18,145,800 of state funds appropriated by the Legislature for MCH activities. A total of $11,496,100 is designated as match for the MCH Block Grant federal funds which exceeds the minimum requirement of $6,057,774. The remaining non-designated state funds will be used in matching Title XIX (Medicaid) and other federal and private funding to expand and enhance MCH programs and activities. Programs including Baby Your Baby, Birth Defects, Tobacco Prevention, Fostering Healthy Children, Baby Watch/Early Intervention, and the Immunization Program significantly benefit from this use of the state funds. CFHS receives private donation and grant funding which is used to enhance selected programs such as Baby Your Baby, Immunization Program, and the Tobacco Prevention Program. Local MCH funds reported reflect county, health district, and other local revenue expended to conduct MCH activities and make services available in local communities.

CFHS assures that at a minimum 30% of the Block Grant allocation is designated for programs for Children with Special Health Care Needs and 30% for Preventive and Primary Care for Children. Special consideration was given to the continuation of funding for special projects in effect before August 31, 1981. Consideration was based on past achievements and the assessment of current needs. Title V funding has been allocated to support these activities which were previously funded [sec.505(a)(5)(c)(i)].

CFHS will maintain budget documentation for Block Grant funding/expenditures for reporting, consistent with Section 505(a), and consistent with Section 506(a)(1) for audit purposes. Audits are conducted by the state auditor's office following the federal guidelines applicable to the Block Grant. In addition, the State Health Department maintains an internal audit staff who reviews local health departments for compliance with federal and state requirements and guidelines for contract/fiscal matters.

CFHS will allocate funds under this title fairly among such individuals, areas, and localities identified in the needs assessment as needing maternal and child health services. Funds are distributed largely according to population, although consideration is given to districts with identifiable maternal and child health needs and factors that influence the availability and accessibility of services. These needs are identified in large part by local communities themselves. The allocation of funds is subject to review by the MCH Advisory Committee. In addition, there are a number of other program-specific advisory groups which have access to funding information for their related programs. These groups provide guidance and support for programs such as Child Fatality Review, WIC, SIDS, Newborn Screening, Baby Watch/Early Intervention, and Tobacco Prevention.

The Department negotiates contracts with each of the twelve local health departments encompassing

many public health functions, and progress is measured against the achievement of the MCH performance measures. The following MCH activities are included: child health clinics, dental health, family planning, injury prevention, prenatal services, school health, speech and hearing screening, and sudden infant and childhood death counseling. The allocation of funds, i.e., contracts, staff, or other budget categories, to meet the maternal and child health needs of the community is left to the discretion of the local health officer. This places the determination of need and the allocation of funds for specific needs at the source of expertise closest to the community. State staff provide local health departments specific data to assist them in determining community needs. Local health department staff and state staff jointly develop an annual plan to address these needs. Annual reports are required from each local health department to monitor MCH activity and document their achievement in impacting the health status indicators for their local MCH populations.

The Division is currently reviewing funding and expenditure trends among programs and contracts which are funded with Title V grant funding. Preliminary review has revealed that local health departments have not been billing against the complete amount of their contracts, which leads to increase carryover. The Division financial and program staff will review contracts to determine more appropriate allocations of the funding so that on a community-level, funds are allocated to better cover the service needs of the health districts. Since some of the contracts are service-specific, changes may need to be made to provide the local agencies with more flexibility with their internal allocation of funding while maintaining services to those most in need.

In an effort to address the increasing unobligated balance of MCH funding, the Division has reviewed individual program budgets to determine the most appropriate funding allocations for each program and made adjustments as needed. Also, based on the Five Year Needs Assessment and other ongoing priorities the Division has identified new priority areas that have been funded for FY06. Funding for these special projects will come from the available carryover funds and will provide opportunities to develop special targeted projects and address such issues as depression and mental health, obesity, medical home, and other topical areas of MCH.

VI. REPORTING FORMS-GENERAL INFORMATION

Please refer to Forms 2-21, completed by the state as part of its online application.

VII. PERFORMANCE AND OUTCOME MEASURE DETAIL SHEETS

For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. GLOSSARY

A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. TECHNICAL NOTE

Please refer to Section IX of the Guidance.

X. APPENDICES AND STATE SUPPORTING DOCUMENTS

A. NEEDS ASSESSMENT

Please refer to Section II attachments, if provided.

B. ALL REPORTING FORMS

Please refer to Forms 2-21 completed as part of the online application.

C. ORGANIZATIONAL CHARTS AND ALL OTHER STATE SUPPORTING DOCUMENTS

Please refer to Section III, C "Organizational Structure".

D. ANNUAL REPORT DATA

This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.